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# Progress on the health-related Sustainable Development Goals and targets in the Eastern Mediterranean Region, 2023

SUSTAINABLE  
DEVELOPMENT  
GOALS



World Health  
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Eastern Mediterranean Region



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# Foreword



The WHO Eastern Mediterranean Region's *Vision 2023: health for all by all – a call for solidarity and action* is anchored in and contributes to the 2030 Agenda for Sustainable Development. Achieving Sustainable Development Goal (SDG) 3, “Ensure healthy lives and promote well-being for all at all ages” will only be possible by also addressing many of the other 16 SDGs as they represent vital social, economic and environmental determinants of health. Although a diverse and dynamic region, the Eastern Mediterranean faces tremendous challenges including widespread poverty, under-resourced health systems, and protracted and acute conflicts and natural disasters.

The first report in this series, *Progress on the health-related sustainable development goals and targets in the Eastern Mediterranean Region, 2020* found progress before the COVID-19 pandemic was not substantial with the Region unlikely to meet the 2030 targets on half of the SDG indicators. The global pandemic has further hampered advances in many countries due to the pressure on health systems as well as economic challenges including high inflation noted in many countries of the Region. Meanwhile, the pandemic also brought into stark relief the importance of health for overall social economic development – putting health at the heart of development priorities once again. As we emerge from three years of pandemic response and diverted attention, we have renewed momentum to accelerate our efforts to achieve the SDGs. This momentum, accompanied by new innovations, technologies and resources – can turn the tide that we have been struggling against for years.

This second report, *Progress on the health-related sustainable development goals and targets in the Eastern Mediterranean Region, 2023* presents country and regional trends, challenges and key actions to accelerate progress on achieving the health-related SDG targets by 2030. The report documents a marked slow-down with setbacks across many indicators on health, health risks and determinants, and access to services in the Region. However, successes at the country level provide glimmers of hope. Since 2010, the under-5 mortality rate in the Region has decreased from 60 deaths per 1000 live births to 45 deaths per 1000 live births and 16 out of 22 countries have achieved the target of 25 or fewer deaths under-five per 1000 live births, while mortality from NCDs dropped by more than 15% in Oman, Qatar and Saudi Arabia. The Universal Health Care service coverage index increased by 10 or more points in Egypt, Islamic Republic of Iran and Qatar.

These glimpses of hope show us that progress is possible. With more effort, better coordination and strengthened commitment by all stakeholders and countries, there is hope that we can still achieve the health-related SDGs by 2030. Broadening partnerships within and across countries and United Nations agencies was critical for the COVID-19 response and is the required approach for achieving SDG 3. Through the Regional Health Alliance, we have established a regional platform of 16 United Nations partners for stronger collaborative support to countries on the health-related SDGs. Let us work together to accelerate progress in achieving our vision of *health for all by all*.

**Dr Ahmed Al-Mandhari**

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# Acronyms and Abbreviations

<b>AIDS</b>	acquired immunodeficiency syndrome	<b>ODA</b>	Overseas Development Assistance
<b>AMR</b>	antimicrobial resistance	<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>APC</b>	alcohol per capita	<b>PCV3</b>	pneumococcal conjugate third dose
<b>DAC</b>	Development Assistance Committee (OECD)	<b>PLHIV</b>	people living with HIV/AIDS
<b>DALY</b>	disability-adjusted life year	<b>PM</b>	particulate matter
<b>DHS</b>	Demographic and health surveys	<b>PPP</b>	purchasing power parity
<b>DTP3</b>	diphtheria-tetanus-pertussis third dose	<b>RHA</b>	Regional Health Alliance
<b>E. coli</b>	<i>Escherichia coli</i>	<b>RMH</b>	reproductive and maternal health
<b>HBsAg</b>	hepatitis B surface antigen	<b>S. aureus</b>	<i>Staphylococcus aureus</i>
<b>HIV</b>	human immunodeficiency virus	<b>SDG</b>	Sustainable Development Goal
<b>HPV</b>	human papillomavirus	<b>SRH</b>	sexual and reproductive health
<b>IHR</b>	International Health Regulations	<b>TB</b>	Tuberculosis
<b>IPC</b>	infection prevention and control	<b>UHC</b>	Universal Health Coverage
<b>MCV2</b>	measles-containing vaccine second dose	<b>UNICEF</b>	United Nations Children's Fund
<b>MENA</b>	Middle East and North Africa	<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>MICS</b>	Multiple Indicator Cluster Surveys	<b>WASH</b>	Water, sanitation and hygiene
<b>MMR</b>	maternal mortality ratio	<b>WHO</b>	World Health Organization
<b>MRSA</b>	methicillin-resistant <i>Staphylococcus aureus</i>	<b>WHO FCTC</b>	World Health Organization Framework Convention on Tobacco Control
<b>NCD</b>	noncommunicable disease		

# Executive Summary

*Successes do exist: since 2010, the under-5 mortality rate in the Region has decreased from 60 deaths per 1000 live births to 45 deaths per 1000 live births, mortality from NCDs has dropped by more than 15% in Oman, Qatar and Saudi Arabia, and the UHC Index has increased by 10 or more points in Egypt, Islamic Republic of Iran and Qatar.*

Streamlining monitoring and reporting of country achievements is a major regional strategic objective for WHO. Our first report, *Progress on the health-related sustainable development goals and targets in the Eastern Mediterranean Region, 2020* documented progress prior to the COVID-19 pandemic and identified key challenges to achieve these targets. This second report, *Progress on the health-related sustainable development goals and targets in the Eastern Mediterranean Region, 2023* presents an update on country and regional trends using data available for 50 health-related indicators (across nine out of 17 SDGs) from January 2010 to June 2023.

The 2023 progress report includes enhancements in the reporting of the health-related indicators from the 2020 report. In response to calls for improved monitoring of inequality, the 2023 report presents disaggregated data for a portion of the indicators. Further efforts have been made to affirm data sources and improve quality control so that a more detailed and accurate picture of regional progress can be presented. Despite WHO and country efforts to improve the quality and availability of data, lack of trend and disaggregated data continues to hamper the monitoring of progress on health-related SDGs at national and regional levels.

Data on the health-related SDGs were compiled from several sources using countries' validated data. United Nations agencies' standardizations or estimates, the WHO Global Health Observatory and the Eastern Mediterranean Regional Health Observatory were the key sources. Regional mean values were obtained from the primary data sources whenever available or calculated using population-weighted approaches if there were at least 10 countries with data available for that indicator.

Progress on the health-related SDG targets at both the regional and country levels shows an anticipated slow-down with setbacks across many indicators on health coverage, health risks, determinants and health status compared to the 2020 report. The slower progress is reflective of the negative impact of the pandemic, economic issues and ongoing complex emergencies faced by half the countries in the Region. Progress on most of the health coverage indicators has been too slow to meet the 2030 targets, although modest improvements were observed on mean coverage of health services, proportion of the population facing financial hardship due to high out-of-pocket payments, and density of health-care personnel. Progress slowed or stalled on health risk factors. A high proportion of children under 5 continue to face malnutrition. Minimal improvements have been made on environmental risks like air pollution, water and sanitation. Unchanged unemployment rates and the high proportion of children not achieving minimum reading proficiency are examples of determinants of health with available data that paint a bleak picture. The minimal progress on health coverage, health risks and determinants explains in part the stalled progress on three quarters of the morbidity and mortality indicators including maternal and child mortality rates, mortality rates due to NCDs and prevalence of key communicable diseases.

Nevertheless, at the country level, successes do exist: since 2010, the under-5 mortality rate in the Region has decreased from 60 deaths per 1000 live births to 45 deaths per 1000 live births, mortality from NCDs has dropped by more than 15% in Oman, Qatar and Saudi Arabia, and the UHC Index has increased by 10 or more points in Egypt, Islamic Republic of Iran and Qatar. As the most intense pandemic response phase came to an end, the lessons learnt from the COVID-19 outbreak and the strengthened public

*Despite disrupting progress, the COVID-19 crisis has also presented an opportunity to propel the SDG agenda forward by underlining the necessity for stronger, more collaborative governance as well as demanding the exploration and use of novel approaches. Though current indicators may not reflect the anticipated progress, the pandemic has instilled resilience and enabled the mobilization of resources that can now be redirected to addressing other health-related matters contributing to the attainment of the SDGs.*

health commitment have once again allowed a shift towards crucial public health priorities, health system strengthening, essential health-care services and the enhancement of national health information systems. Country successes demonstrate possibilities and provide inspiration to build the momentum to address priorities that may have slipped off the radar during the pandemic.

Large inter-country differences exist both in the current status and in the progress being made towards the SDGs across most indicators. The unavailability of data for around one in five indicators – a quarter of data reported is from 2019 or earlier – hinders progress reporting. At the same time, lack of disaggregated data impedes efforts to promote health equity through gender- and equity-sensitive policies and programmes. This limited data disaggregation by age, sex, place of residence and other variables is a major barrier to generating information through a gender and equity lens to inform public health action and “leave no one behind”. Improving the availability of disaggregated data would allow us to monitor and guide relevant evidence-informed policy changes and implementation to address inequities. These perspectives demonstrate the need for more and stronger action for better results.

Achieving the health-related SDGs requires bold action across four areas: (i) advancing universal

health coverage by investing in quality, accessible and integrated health services over the life-course; (ii) adopting an all-hazards, whole-of-government approach to public health preparedness and response; (iii) addressing health risks and determinants by promoting comprehensive multisectoral coordination policies and mechanisms to adopt and implement; and (iv) expanding evidence-based and data and research-informed gender- and equity-sensitive policy-making. These measures are not new: they were spelled out in the 2020 report as well as in previous decisions of WHO governing bodies by the Member States and the Secretariat.

Despite disrupting progress, the COVID-19 crisis has also presented an opportunity to propel the SDG agenda forward by underlining the necessity for stronger, more collaborative governance as well as demanding the exploration and use of novel approaches. Though current indicators may not reflect the anticipated progress, the pandemic has instilled resilience and enabled the mobilization of resources that can now be redirected to addressing other health-related matters contributing to the attainment of the SDGs. Together, it is possible to accelerate progress toward the health-related SDGs in the Eastern Mediterranean Region, for example through joint United Nations platforms such as the Regional Health Alliance, and to achieve health for all by all.

# Introduction





Achieving the 2030 Agenda for Sustainable Development requires monitoring progress on the Sustainable Development Goals (SDGs) at all levels. Streamlining monitoring and reporting of country achievements is a strategic objective for WHO (1). The first report in this series, *Progress on the health-related sustainable development goals and targets in the Eastern Mediterranean Region, 2020* documented progress in the Region prior to the COVID-19 pandemic and identified key challenges to achieve these targets (2). According to the report, weak governance, fragmentation of health services, emergencies and humanitarian settings, unavailability of key data, and inadequate attention to gender disparity and other equity concerns were the key threats in countries of the Region to achieving the SDGs by 2030. Since the commissioning of the first report, the COVID-19 pandemic has resulted in new threats to health and its social determinants. Meanwhile, instability in conflict-affected and humanitarian settings continues to undermine any progress.

This second report, *Progress on the health-related sustainable development goals and targets in the Eastern Mediterranean Region, 2023* presents an update on country and regional trends on SDGs and targets using data available for 50 indicators (across nine out of 17 SDGs) from January 2010 to June 2023. This report, alongside the national SDG progress reports and the voluntary national reviews submitted to the high-level political forum, is a key way to monitor progress.

Achieving SDG 3, “Ensure healthy lives and promote well-being for all at all ages” will only be possible if the objectives represented within other SDGs (Fig. 1) are also addressed, as they include important social, economic and environmental determinants of health: (a) risk factors that have direct effects on health (SDGs 2, 6, 7, 11, 13 and 16); (b) determinants of health (SDGs 1, 4, 5, 8, 9, 12, 14 and 15); or (c) cross-cutting issues (SDGs 10 and 17). In addition, the achievement of universal health coverage (UHC) (target 3.8) is key to achieving all the other SDG 3 targets, whether

Fig. 1. Health in the SDG era



Source: Global Health Observatory. Monitoring health for the SDGs (<https://www.who.int/health-topics/sustainable-development-goals>).

these are related to mortality (targets 3.1, 3.2, 3.4, 3.6 and 3.9) morbidity (targets 3.3, 3.5 and 3.7) or means of implementation (targets 3.a–d).

This progress report includes enhancements in reporting of the health-related indicators from the 2020 progress report in several ways. As recommended by the Commission on Social Determinants of Health in the Eastern Mediterranean Region (3) and in response to the call for improved monitoring on inequalities from the earlier report and at the launch of the Health Inequality Data Repository (4), this report presents disaggregated data for a portion of the indicators. Further efforts have been made to affirm data sources and improve quality control so that a more detailed and accurate picture of regional progress could be presented. Despite WHO and country efforts to improve the quality and availability of data, lack of trend and disaggregated data continues to hamper

our ability to monitor trends on the health-related SDGs at national and regional levels.

The presentation of progress on the SDGs follows a similar format to the previous report: 33 fact sheets outline country and regional trends for each of the health-related targets and indicators. Disaggregated data is also presented where possible. Each fact sheet presents national and regional challenges to be overcome and the steps required to accelerate progress if targets are to be met by 2030. To support countries in achieving each of the targets, a range of WHO-related policies, plans and tools are also identified. Highlights of key findings are found in a separate chapter that collates the main findings presented in the fact sheets. Finally, the “Way forward” chapter outlines the main steps needed to achieve the health-related SDGs and targets in the Region based on the progress observed so far.

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# Data and Methodology

*Monitoring progress towards the health-related SDGs and targets requires high-quality and timely data from each country to track changes against specific indicators.*



Monitoring progress towards the health-related SDGs and targets requires high-quality and timely data from each country to track changes against specific indicators. In 2012, Eastern Mediterranean Region Member States endorsed a resolution to report a core set of indicators annually which has now expanded to nearly 95 indicators with additional SDG-related indicators. They focus on three main components: monitoring health determinants and risks, assessing health status including morbidity and cause-specific mortality and assessing the health system response. From these, fifty indicators covering the health-related SDGs indicators across nine out of 17 SDGs were selected to best monitor progress. There is no single source of data for monitoring progress towards the health-related SDGs for countries of the Region covering the period of interest from 2015 (SDG baseline). Most reliable data for each SDG indicator should ideally be collected according to the approved definitions and sources (metadata) for the indicators. For many countries of the Region, such data remain scarce for several SDG indicators.

Data on health-related SDGs were therefore compiled from several sources, including the WHO Global Health Observatory (1); the WHO Eastern Mediterranean Region Health Observatory (2); the UNESCO Institute for Statistics SDG 4 database (3); estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation (4); the WHO immunization data portal (5); Global data on HIV epidemiology and response (6); WHO prevalence estimates for intimate partner and non-partner sexual violence against women (7); WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division estimates of trends in maternal mortality, 2000 to 2020 (8); World Bank Open Data (9); World Malaria Report 2022 (10); WHO Global Tobacco Control Policy Data (11); and the WHO Maternal, Newborn, Child and Adolescent Health and Ageing Data Portal (12). The greatest share of data used came from the WHO Global Health Observatory, since this is the repository of the WHO regional core health indicators, which are based on data reported by Member States to WHO each year. Efforts were made to ensure that the reference years shown for data obtained from published reports and electronic databases corresponded to the years in which the data were collected and not the year in which the data were published.

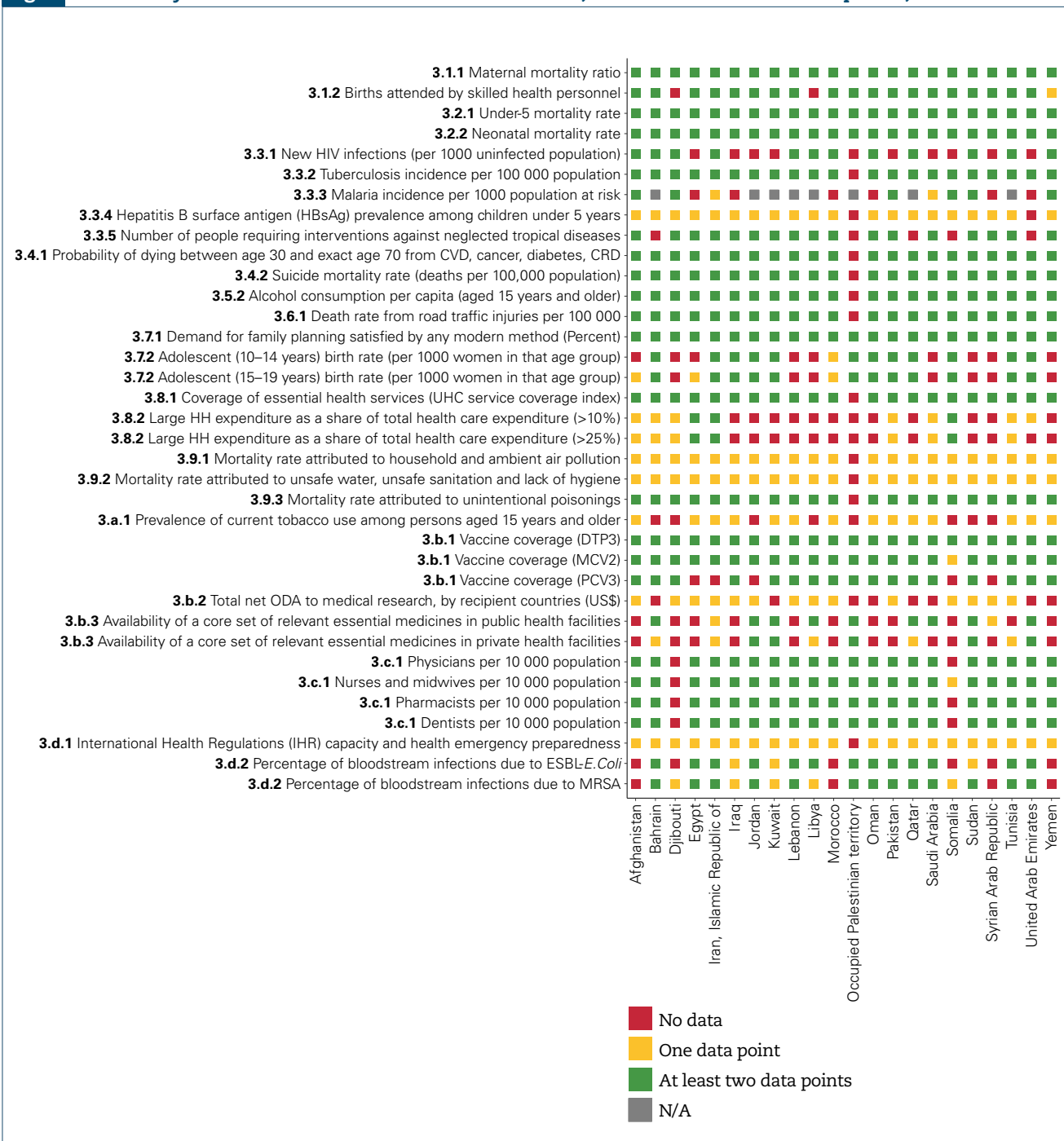
For most indicators including child mortality, data were available for as recently as 2022. However, a number of indicators had data available only for 2019 or earlier. In cases where data were not consistently available in the same year for most countries, the data values were grouped into periods of years (e.g. 2013–2015). The value in the most recent year was given preference in grouping the values into periods (for the 2013–2015 period, the value for 2015 would be given preference followed by the value for 2014 and lastly, the value for 2013).

Regional mean values were obtained from the primary data sources whenever available for most indicators. For selected indicators with no published regional values, regional means were calculated as population-weighted means. The population numbers used in calculating the population-weighted means for the Region were obtained from *World Population Prospects 2022*, available from the United Nations Population Division Data Portal (13). For any indicator, the population-weighted mean for the Region was calculated only if there were at least 10 countries with data available for that indicator.

For all indicators, charts were prepared from the available data. Regional means based on published data (or population-weighted means for indicators with no published regional means) were plotted to show data availability and trends since 2015. For selected indicators, data were available from 2010 and provided an opportunity to assess trends prior to the SDG baseline year of 2015. All sources of data were validated by the authors after consultation with the relevant technical departments at the WHO Regional Office for the Eastern Mediterranean.

More details on the sources of data are provided in Annex 1, while Annex 2 indicates where further information can be found on the development of the global indicator framework and on the metadata used for each indicator. Annex 3 summarizes data availability across all indicators, by country and year. As shown in Fig. 2, the availability of data on SDG 3 target indicators varies considerably over the period 2015–2022, with substantial gaps existing across indicators on cause-specific mortality.

**Fig. 2. Availability of data for each SDG 3 indicator: no data, one and at least two data points, 2015–2022**

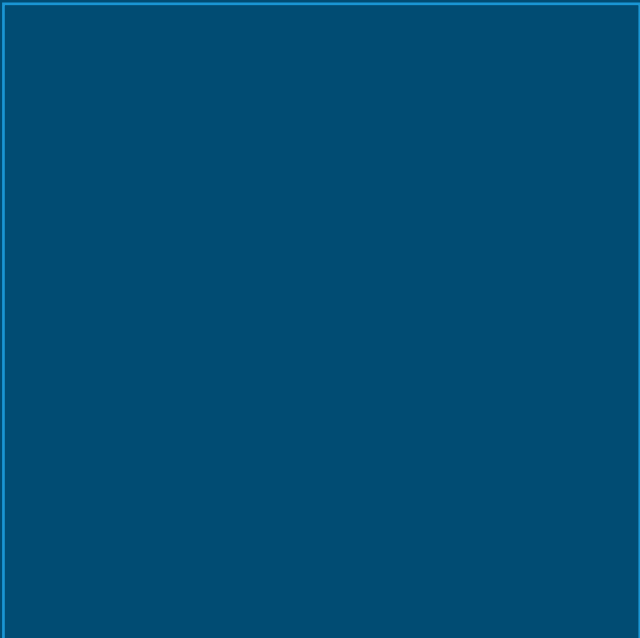
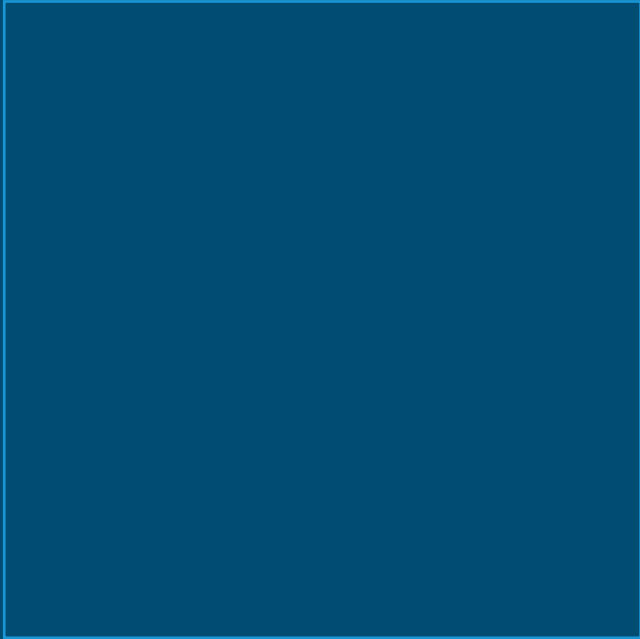
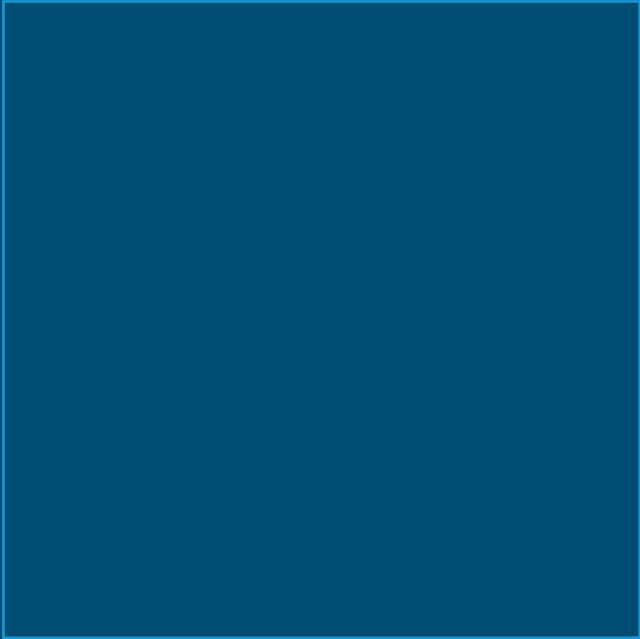


## Key references

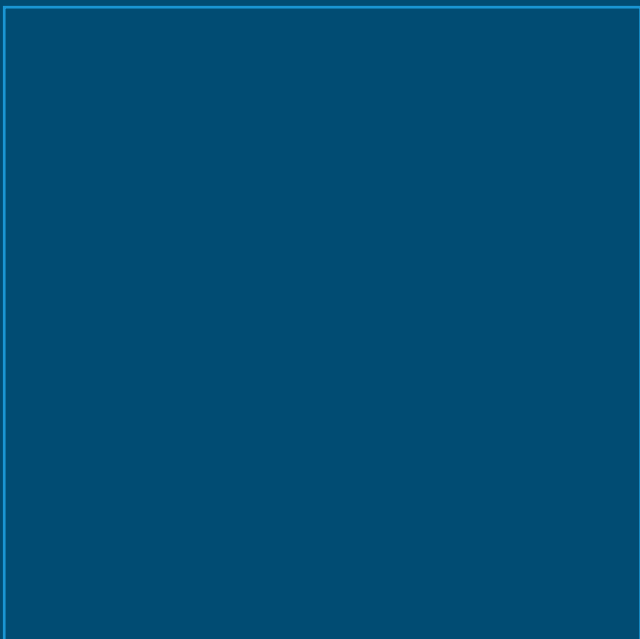
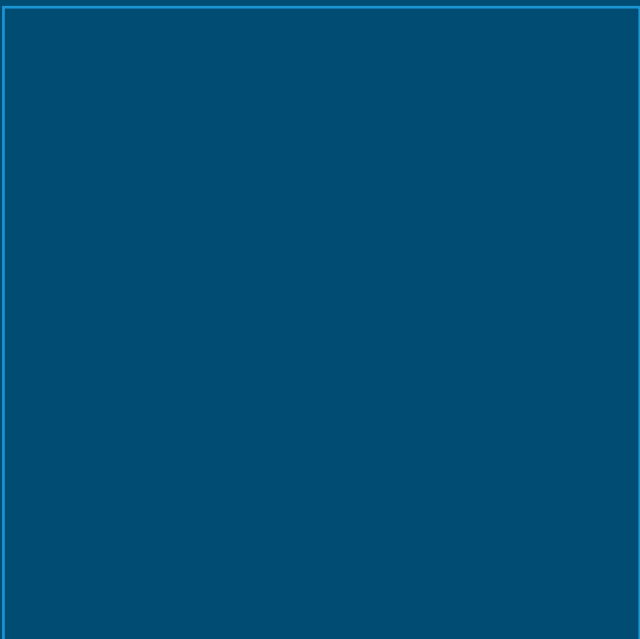
1. WHO Global Health Observatory (<https://www.who.int/data/gho/data/indicators>).
2. WHO Regional Office for the Eastern Mediterranean; Eastern Mediterranean Data Repository (<https://rho.emro.who.int/drs>).
3. SDG4 March 2023 Release [online database]. UNESCO Institute for Statistics Technical Cooperation Group. New York (<http://sdg4-data.uis.unesco.org>).
4. United Nations Inter-agency Group for Child Mortality Estimation. 2023 (<https://childmortality.org/data>).
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7. Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva: World Health Organization; 2021.
8. Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023 (<https://www.who.int/publications/i/item/9789240068759>).
9. World Bank Open Data (<https://data.worldbank.org>).
10. World malaria report 2022. Geneva: World Health Organization; 2022 (<https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2022>).
11. WHO Global Tobacco Control Policy Data (<https://www.who.int/publications/i/item/WHO-HEP-HPR-TFI-2021.10>).
12. WHO Maternal, Newborn, Child and Adolescent Health and Ageing Data Portal ([https://www.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/proportion-of-women-aged-15-49-who-make-their-own-informed-decisions-regarding-sexual-relations-contraceptive-use-and-reproductive-health-care-\(sdg-5.6.1\)](https://www.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/proportion-of-women-aged-15-49-who-make-their-own-informed-decisions-regarding-sexual-relations-contraceptive-use-and-reproductive-health-care-(sdg-5.6.1))).
13. United Nations Population Division Data Portal (<https://population.un.org/dataportal/home>).







*A total of 50 health-related SDG indicators are analysed and presented in this report by Goal, as follows.*



# Goal 1

## End poverty in all its forms everywhere

**Target 1.1:** By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than US\$ 1.25 a day

■ **Indicator 1.1.1:** Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)

### Current situation

- In September 2022, the World Bank updated the global poverty lines. The new extreme poverty line is US\$ 2.15 at 2017 purchasing power parity (PPP) per person per day, replacing the previous value of US\$1.25 per person per day.
- Only a handful of countries in the Region have data available for this indicator.
- During the period 2014–2016, the proportion of the population living below the international poverty

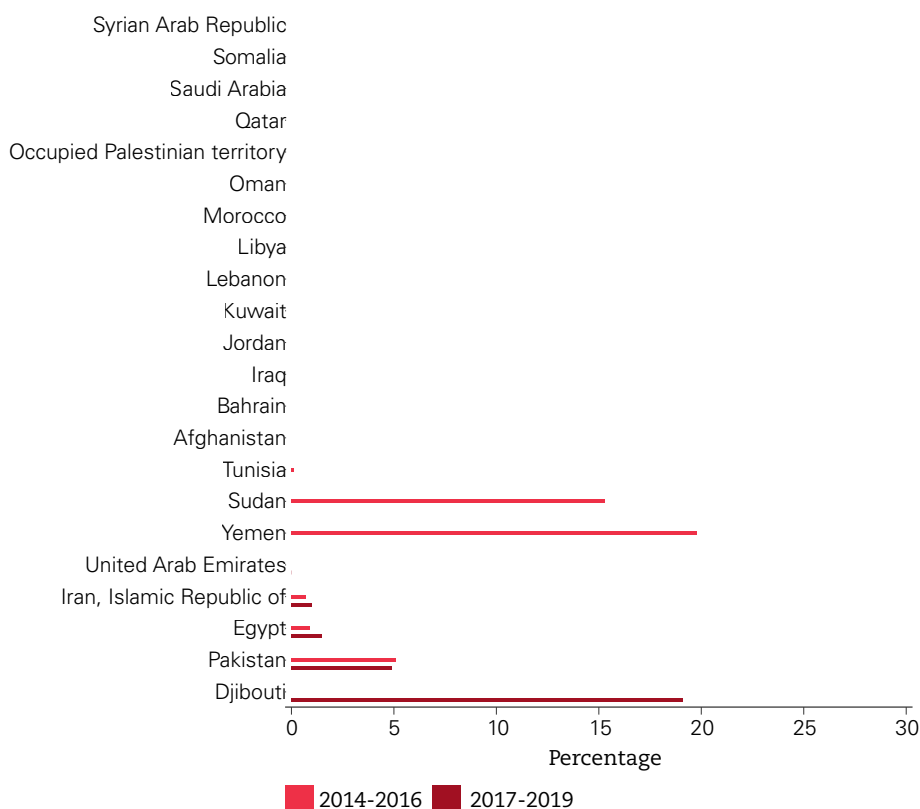
line at \$2.15 (2017 PPP), among five countries with reported data, was highest in Yemen (19.8% in 2014) and lowest in Tunisia (0.1% in 2015).

- During the period 2017–2019, the proportion was highest in Djibouti (19.1% in 2017) and lowest in the United Arab Emirates (0.01% in 2018).
- For countries in the Region with reported data, the population-weighted mean proportion of the population living below the international poverty line (3.7% in 2018) was lower than the global proportion of 8.5% in 2019.

### Key message

- Although limited data on poverty estimates in most countries of the Region hamper the ability to reliably track progress in achieving SDG 1, reforming health, financial and social protection would expand universal health coverage and reduce out-of-pocket costs that push the poorest below or further below the poverty line.

### 1.1.1 Proportion of population living below the international poverty line (%), 2014–2019



## Challenges

- International poverty lines allow for comparison across countries but do not reflect national poverty lines.
- According to the World Bank, one in five people in the Middle East and North Africa (MENA) live near violent conflict, with chronic violence contributing to the increase in regional poverty. Nearly half of the economies in the MENA region are classified as fragile and conflict-affected states.
- Since the war in Ukraine began, it is estimated that more than 20 million people in the MENA have fallen into poverty due to rising prices and stagnant incomes.
- The COVID-19 pandemic exacerbated economic vulnerabilities in the Region through rising food prices, lost income and employment, and reductions in humanitarian assistance to conflict-affected states. The impact is likely to continue to be felt for decades to come. Many countries have not showed signs of significant economic recovery so far.

## Steps for accelerated action

The 2020 United Nations High-Level Meeting on Trends, Options and Strategies in Poverty Eradication Across the World recommended the following actions:

- people-centred public policies should be instituted to allow for scaled-up investment in universal health care, education, social protection, equitable access to digital technology, and support to micro- and medium-sized enterprises;
- the oversight, regulatory and coordination functions of the public sector should be strengthened, taking into account the effective engagement of civil society and the private sector;
- small- and medium-sized enterprises, including women-led businesses, should be helped to grow and to contribute their fair share to the eradication of poverty; and
- urgent international cooperation should be mobilized to support developing countries through the allocation of an extra recovery package, provision of liquidity and financial assistance through postponement of debt repayment.

## Available guidance/tools

- Report of the High-Level Meeting on “Trends, options and strategies in poverty eradication across the world” and the inauguration of the

Alliance for Poverty Eradication [Internet]. 30 June 2020 ([https://www.un.org/pga/74/wp-content/uploads/sites/99/2020/06/UN\\_PGA\\_HLM-on-Poverty-Eradication-and-Alliance-Launch\\_Report\\_FINAL4\\_30Jul020-1.pdf](https://www.un.org/pga/74/wp-content/uploads/sites/99/2020/06/UN_PGA_HLM-on-Poverty-Eradication-and-Alliance-Launch_Report_FINAL4_30Jul020-1.pdf), accessed 25 June 2023).

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- United Nations Economic and Social Commission for Western Asia (ESCWA), and other (2023). Second Arab Multidimensional Poverty Report. E/ESCWA/CL2.GPID/2022/4. Beirut (<https://www.unescwa.org/sites/default/files/pubs/pdf/second-arab-multidimensional-poverty-report-english.pdf>, accessed 3 August 2023).
- World Bank. Fact Sheet: An Adjustment to Global Poverty Lines (<https://www.worldbank.org/en/news/fact-sheet/2022/05/02/fact-sheet-an-adjustment-to-global-poverty-lines>, accessed 2 August 2023).

## Data sources

- World Bank Data (<https://data.worldbank.org/indicator/SI.POV.DDAY?end=2022&start=2000&view=chart>)

## Goal 2

# End hunger, achieve food security and improved nutrition and promote sustainable agriculture

**Target 2.2:** By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons

■ **Indicator 2.2.1:** Prevalence of stunting (height for age  $<-2$  standard deviation from the median of the World Health Organization Child Growth Standards) among children under 5 years of age

### Current situation

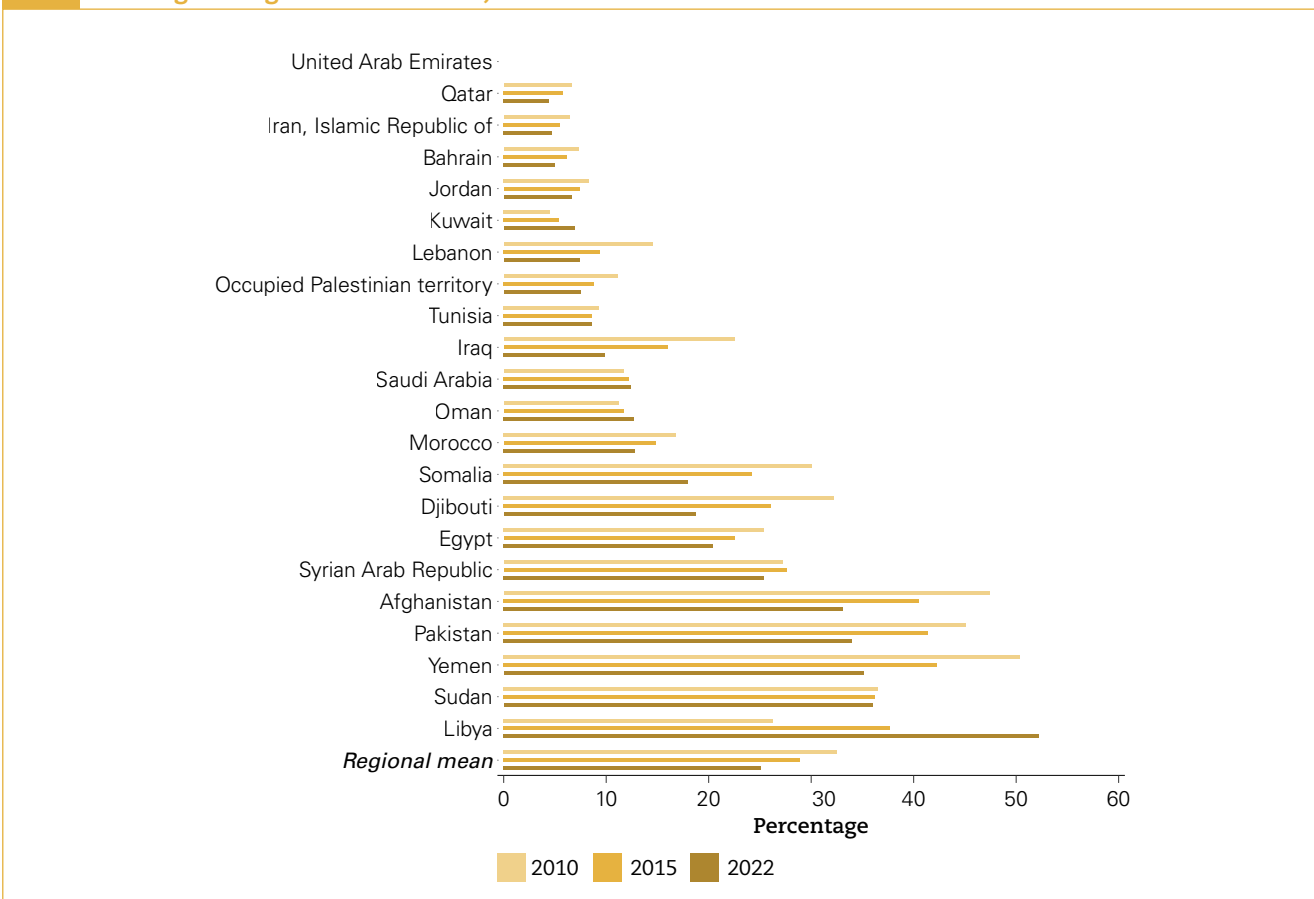
- There are wide variations in trends and prevalence of stunting among children under 5 years of age in countries of the Region.
- The prevalence of stunting among children under 5 years of age in the Region declined from 33% in

2010 to 29% in 2015 and to 25% in 2022.

- Since 2010, the prevalence of stunting reduced by more than 10% in Afghanistan, Djibouti, Islamic Republic of Iran, Pakistan, Somalia and Yemen. Libya, however, was the only country with a dramatic increase: by 2020, 52% of children under 5 were stunted.
- In 2022, the prevalence of stunting among children under 5 in the Region was 30% or more in Afghanistan, Pakistan, Yemen, Sudan and Libya.
- In 2022, the prevalence of stunting among children under 5 in the Region was lowest in Qatar (4.4%) and highest in Libya (52.2%).

■ **Indicator 2.2.2:** Prevalence of wasting (weight for height  $>-2$  standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age

### 2.2.1 Stunting among children under 5, 2010–2022



### Current situation

- Limited trend data is available for most countries, while some countries report no data at all.
- Based on the latest data available, during the period 2017–2022, the prevalence of wasting among children under 5 years of age in countries of the Region ranged from less than 1% in Jordan to 14% in Sudan.
- Of the 16 countries in the Region with available data, eight countries have not yet met the World Health Assembly global target for 2025 of reducing and maintaining childhood wasting to less than 5%.

■ **Indicator 2.2.2: Prevalence of overweight (weight for height >+2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age**

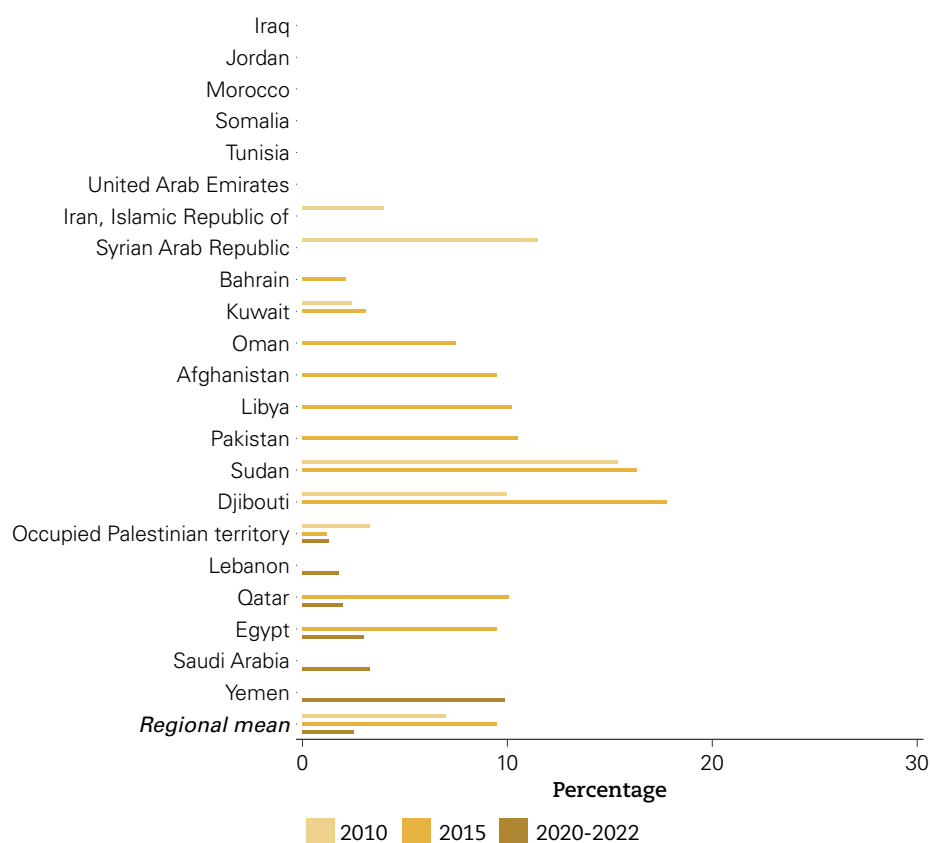
### Current situation

- In 2022, the prevalence of overweight among children under 5 years of age ranged from 1.7% in Yemen to 28.7% in Libya. The median value was 7% among the 20 countries with data.
- Since 2010, Iraq, Morocco, Pakistan and United Arab Emirates reported a decrease of at least 2% in the prevalence of overweight among children under 5; in contrast, Egypt, Jordan, Kuwait, Oman and Tunisia reported an increase of 3.1% or more.
- The regional mean value of overweight reduced slightly between 2015 and 2022 from 6.9% to 6.3%.

### Key message

- Ensure universal access to healthy and sustainable diets by implementing evidence-based nutrition policies and public health actions throughout the life-course to prevent undernutrition, overweight, obesity and diet-related NCDs. Support and protect nutrition in emergency situations.

## 2.2.2 Wasting among children under 5, 2010–2022



Goal  
2

**Challenges**

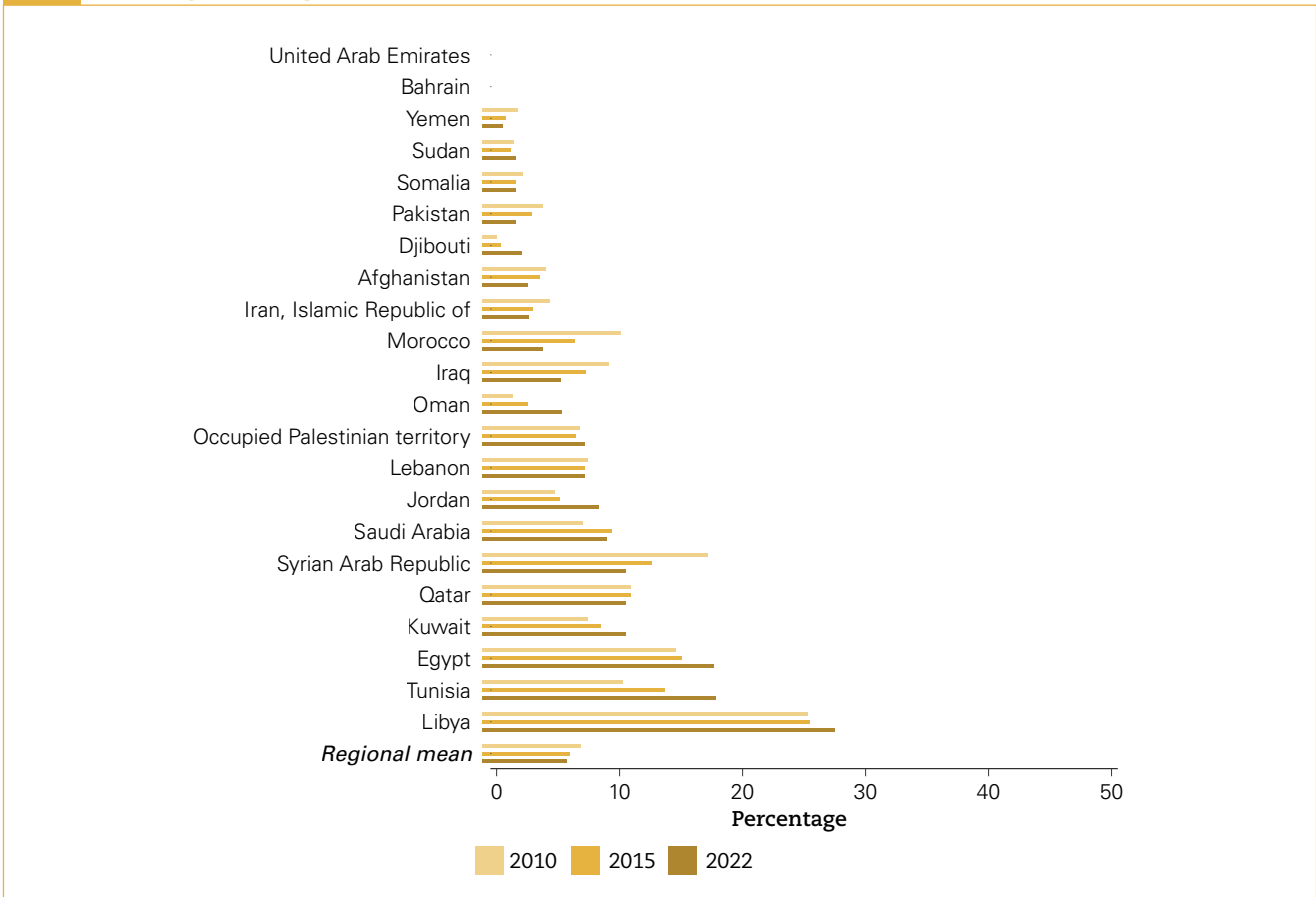
- Conflict, environmental threats and natural disasters are key environmental and structural challenges to food security and nutrition which were amplified by the COVID-19 pandemic.
- Global food prices reached an all-time high in 2022. The drivers of the price increase have been the war in Ukraine which has disrupted global supplies of wheat, maize and other crops, as well as fertilizer, creating further pressure on prices and additional challenges to ensuring food security for many countries, and pandemic-related supply chain disruptions.
- Limited government commitment and low investment of finances and human resources to address the double burden of malnutrition, especially in low- and middle-income countries.
- Limited regulatory measures and fiscal policies to support healthy diets and physical activity among young children, and to address the shift in food consumption towards diets high in salt, fat and sugar in most countries of the Region.

- Marketing of unhealthy food targeting children and adolescents, especially via social media.
- Limited nutrition and health data, few recent studies examining the nutritional status of children under 5, the scarcity of national studies evaluating micronutrient deficiencies and the lack of nationally representative dietary intake studies in children.

**Steps for accelerated action**

- Strong government leadership, increased political and financing support, and multisectoral engagement are crucial for effective action on nutrition.
- Comprehensive multisectoral coordination mechanisms are needed at various levels for policies to promote healthy diets rich in fruits and vegetables and low in salt, fat (total fat, saturated fatty acids and trans fatty acids) and sugar, especially among schoolchildren and adolescents, and to ensure access to nutritious, diverse, safe and affordable foods. Promoting breastfeeding (exclusive for the first six months

**2.2.2 Overweight among children under 5, 2010–2022**



and continued for two years) and nutritionally-balanced complementary feeding for children under 5 is also a key preventive and cost-effective intervention for addressing obesity and NCDs.

- Strengthen the delivery and reach of nutrition counselling and social and behaviour change interventions at the community and facility level.
- Build human resource capacity through the training of nutrition professionals (nutritionists and dietitians) and provide nutrition-related training to health professionals and other frontline workers.
- Conduct research to address knowledge gaps and develop culture-specific and evidence-based intervention strategies aimed at improving the nutritional status of the population in the countries.

#### Available guidance/tools

- WHO Regional Office for the Eastern Mediterranean. Strategy on nutrition for the Eastern Mediterranean Region 2020–2030. Cairo; 2019 (<http://applications.emro.who.int/docs/9789290222996-eng.pdf?ua=1>).
- WHO Regional Office for the Eastern Mediterranean. Wheat flour fortification in the Eastern Mediterranean Region. Cairo; 2019 ([http://applications.emro.who.int/docs/EMROPUB\\_2019\\_EN\\_22339.pdf?ua=1](http://applications.emro.who.int/docs/EMROPUB_2019_EN_22339.pdf?ua=1)).
- International Code of Marketing of Breast-milk Substitutes and relevant WHA resolutions. Relevant WHA resolutions can be found at: <https://www.who.int/health-topics/breastfeeding>.
- WHO Regional Office for the Eastern Mediterranean. Regional framework for action on obesity prevention 2019–2023. Cairo; 2019 ([http://applications.emro.who.int/docs/EMROPUB\\_2019\\_en\\_22319.pdf?ua=1](http://applications.emro.who.int/docs/EMROPUB_2019_en_22319.pdf?ua=1)).
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- Regional overview of food security and nutrition. Building resilience for food security and nutrition in times of conflict and crisis: a perspective from the Near East and North Africa Region. Cairo: Food and Agriculture Organization of the United Nations; 2017 (<http://www.fao.org/3/I8336EN/i8336en.pdf>).
- Call to action to address maternal and child undernutrition in the Middle East and North Africa, Eastern Mediterranean and Arab regions: with a focus on Afghanistan, Djibouti, Lebanon, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen. Cairo: WHO Regional Office for the Eastern Mediterranean; 2022 (<https://applications.emro.who.int/docs/WHOEMNUT289E-eng.pdf?ua=1>).

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# Goal 3

## Ensure healthy lives and promote well-being for all

**Target 3.1:** By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births

■ **Indicator 3.1.1: Maternal mortality ratio**

**Current situation**

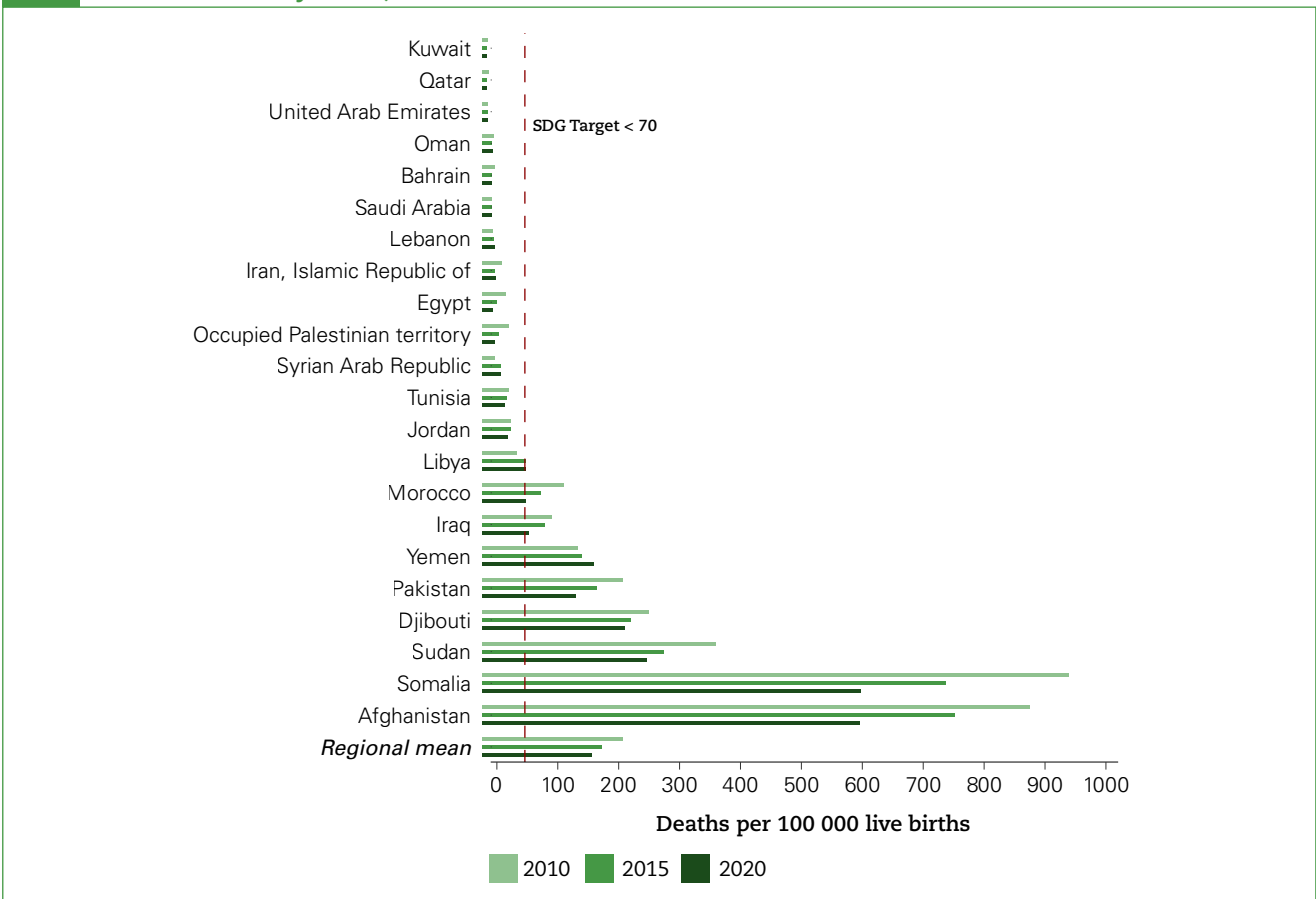
- As of 2020, 13 countries of the Region had met the SDG target for a maternal mortality ratio (MMR) of less than 70 deaths per 100 000 live births, while three countries had an MMR of between 72 and 76 deaths per 100 000 live births.
- The supplementary national target is that no country should have an MMR of more than 140 deaths per 100 000 live births (twice the global target) by 2030. As of 2020, six countries (Somalia, Afghanistan, Sudan, Djibouti, Yemen and Pakistan) in the Region reported an MMR of more than 140 deaths per 100 000 live births.

- The regional maternal mortality ratio fell from 231 to 196 deaths per 100 000 live births between 2010 and 2015, then to 179 maternal deaths per 100 000 live births by 2020.
- Since 2010, the MMR has halved or more in Egypt and occupied Palestinian territory and decreased by at least one third in Iraq, Morocco, Pakistan and Somalia; however, the MMR worsened in Lebanon, Libya, Somalia and Syria, demonstrating the impact of the humanitarian crises and emergency situations they are facing.

**Key message**

- Integrate sexual and reproductive health (SRH) at policy, programme and service levels to address key causes of maternal mortality, reproductive and maternal morbidities and promote positive reproductive and maternal health outcomes.

### 3.1.1 Maternal mortality ratios, 2010–2020





## Challenges

- Insufficient adoption of the updated WHO SRH recommendations and guidelines into national policies, programmes and services.
- Fragmented service delivery mechanisms lacking SRH integration and adoption of continuum of care.
- Shortage in health-care workforce and deficiencies in trained human resources for SRH services.
- Inequalities and inequities in access to, and quality of, SRH care services.
- Limited health system response to SRH needs in emergencies and humanitarian settings.
- Sociocultural barriers and lack of policies preventing women and girls from achieving their right to positive sexual and reproductive health outcomes.
- Lack of sufficient granularity and quality in the available data to guide programme planning improvements and respond to women's and girls' health needs.

## Steps for accelerated action

- Ensure SRH integration at policy, programme and service levels, and address the causes of maternal mortality, reproductive and maternal morbidities, and related disabilities.
- Ensure equitable distribution of SRH trained workforce and strengthen the skills of health providers in delivering SRH services.
- Ensure equitable reproductive and maternal health (RMH) coverage and better quality of care services in line with WHO latest SRH recommendations and guidelines.
- Strengthen information, education and communication for SRH services and rights to promote positive RMH outcomes.
- Promote and encourage the use of SRH indicators and surveillance systems (for example, for maternal and perinatal death surveillance and response activities) to improve quality of care and accountability.

## Available guidance/tools

- WHO. The global strategy for women's, children's and adolescents' health (2016–2030) ([https://www.who.int/publications/i/item/the-global-strategy-for-women-s-children-s-and-adolescents-health-\(2016-2030\)-early-childhood-development-report-by-the-director-general](https://www.who.int/publications/i/item/the-global-strategy-for-women-s-children-s-and-adolescents-health-(2016-2030)-early-childhood-development-report-by-the-director-general))
- WHO recommendations on antenatal care for a positive pregnancy experience. 2016 (<https://www.who.int/publications/i/item/9789241549912>)

- WHO recommendations: intrapartum care for a positive childbirth experience. 2018 (<https://www.who.int/publications/i/item/9789241550215>)
- WHO labour care guide: user's manual. 2021 (<https://www.who.int/publications/i/item/9789240017566>)
- WHO recommendations on maternal and newborn care for a positive postnatal experience. 2022 (<https://www.who.int/publications/i/item/9789240045989>)
- Robson Classification: implementation manual. 2017 (<https://www.who.int/publications/i/item/9789241513197>)
- Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death. 2013 (<https://www.who.int/publications/i/item/9789241506083>)
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- Souza JP, Tunçalp Ö, Vogel JP, Bohren M, Widmer M, Oladapo OT, et al. Obstetric transition: the pathway towards ending preventable maternal deaths. BJOG. 2014;121(Issue s1):1–4 (<https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.12735>)
- Say L, Chou D, Gemmill A, et al. Global causes of maternal death: a WHO systematic analysis. Lancet Global Health. 2014;2(6): e323–e333.

## Data sources

- Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division (<https://www.who.int/publications/i/item/9789240068759>)

**Indicator 3.1.2: Proportion of births attended by skilled health personnel**

**Current situation**

- During the period 2018–2021, the proportion of births attended by skilled health personnel in half of the countries of the Region was almost universal (> 99.2%) and was at least 90% in 14 countries.
- In 2018–2021, the proportion of births attended by skilled health personnel in the Region was lowest in Somalia (31.9%), Sudan (51.2%) and Afghanistan (58.8%).
- Eight of the countries with data on trends showed an increase in the proportion of births attended by skilled health personnel between the periods 2011–2015 and 2018–2021, with the largest increase seen in Pakistan (rising from 58.8% in 2011–2015 to 74% in 2018–2021).

- Seven of the countries with data on trends showed a reduction in the proportion of births attended by skilled health personnel between the periods 2011–2015 and 2018–2021, with the largest reduction seen in Sudan (falling from 77% during the period 2011–2015 to 51.2% during the period 2018–2021).

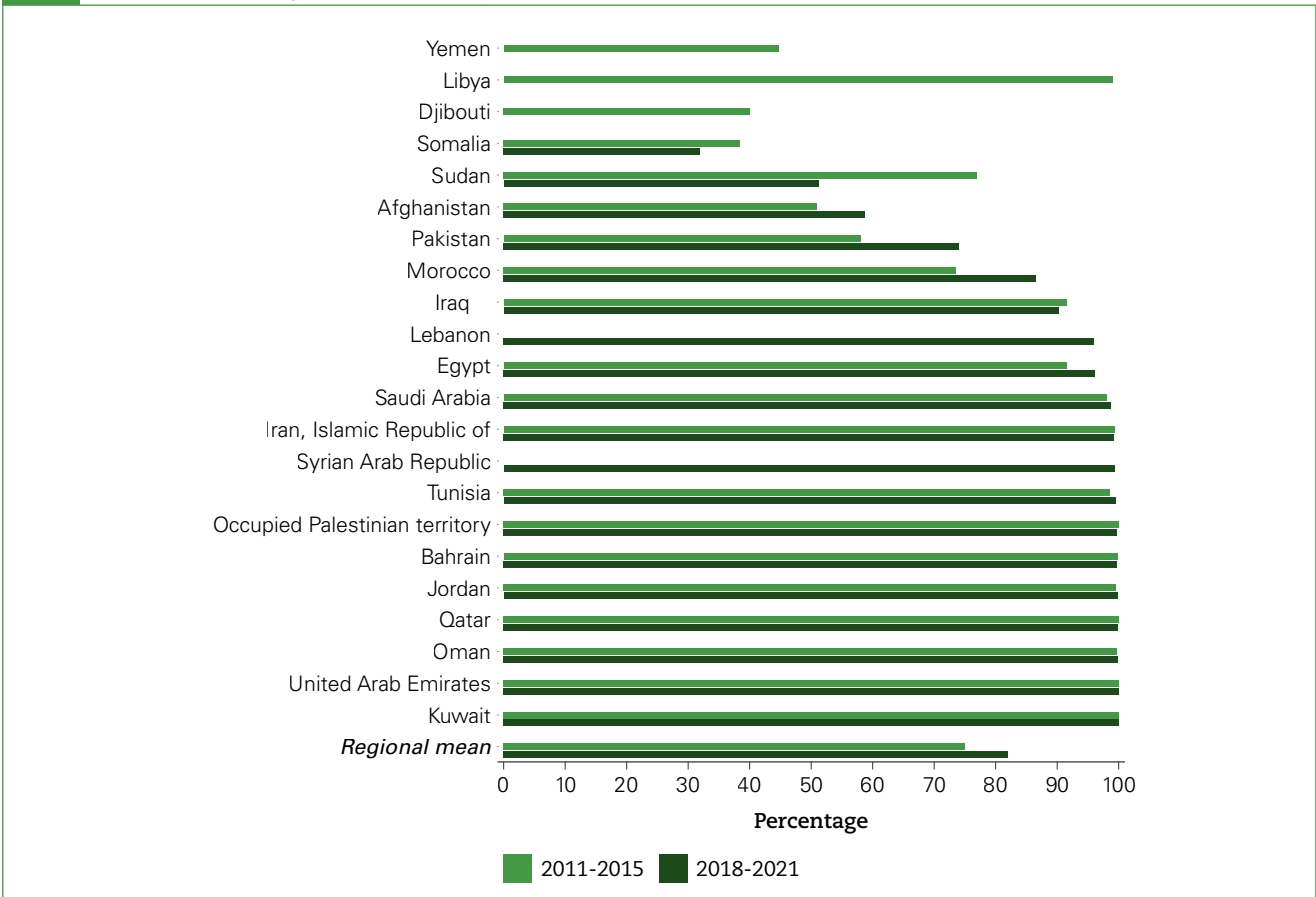
**Key message**

- Skilled care at the time of delivery is a triple investment (reducing maternal deaths, and newborn deaths and stillbirths) and contributes to a positive childbirth experience; implementing the latest comprehensive and consolidated WHO guidelines on essential intrapartum care helps to ensure good quality institutional deliveries.

**Challenges**

- Deficiencies in sexual and reproductive health and rights regulations, policies, strategies and quality-assurance processes.

**3.1.2 Births attended by skilled health personnel, 2011-2021**



- Shortages of trained health personnel and suboptimal distribution of the available workforce are compounded by poor infrastructure and equipment at health facilities. The result is poor-quality care, threatening patient safety.
- Non-availability of defined referral/communication pathways, lack of health facilities for emergency transport of pregnant women at high risk and women in labour requiring emergency obstetric care.
- Shortages of essential sexual and reproductive medicines, logistics and supplies have affected low-income countries and settings with humanitarian crises.
- The COVID-19 pandemic negatively impacted the continuity of sexual and reproductive health services at both primary care and secondary care levels. This affected the quality of childbirth care services across the Region, especially in countries facing humanitarian crises.
- Increase the availability of skilled health personnel for maternal and newborn care and ensure their equitable deployment and skills strengthening for the improvement of labour and childbirth care.
- Ensure continuity of care by including birth preparedness and complication or emergency readiness plans for every pregnant woman, emphasizing institutional quality of delivery care.
- Secure adequate equipment, supplies and medicines to support implementation of the WHO recommendations on intrapartum care for a positive childbirth experience.
- Implement innovative ways of encouraging high-quality skilled care at time of delivery, building on national and regional best practices including demand-side financing schemes.

#### Available guidance/tools

- WHO recommendations: intrapartum care for a positive childbirth experience. 2018 (<https://www.who.int/publications-detail-redirect/9789241550215>)
- Key points for considering adoption of the WHO labour care guide: policy brief. 2022 (<https://www.who.int/publications/i/item/9789240055766>)
- WHO labour care guide ([https://cdn.who.int/media/docs/default-source/reproductive-health/maternal-health/who-labour-care-guide.pdf?sfvrsn=bd7fe865\\_15](https://cdn.who.int/media/docs/default-source/reproductive-health/maternal-health/who-labour-care-guide.pdf?sfvrsn=bd7fe865_15))
- WHO labour care guide: user's manual. 2021 (<https://www.who.int/publications/i/item/9789240017566>)

#### Data sources

- WHO Eastern Mediterranean Health Observatory. Skilled births attendance (<https://rho.emro.who.int/Indicator/TermID/94>)

#### Steps for accelerated action

- Ensure good quality, evidence-based, respectful care during labour and childbirth irrespective of the setting or level of health care by facilitating effective implementation of the WHO recommendations on intrapartum care for a positive experience.
- Train and guide skilled health personnel to offer woman-centred, supportive care throughout labour and childbirth and assist them to promptly identify emerging labour complications and trigger WHO recommended actions.
- In locations where geographical access is difficult, consider developing “maternity waiting homes” (as per standards or similar structures) to enable mothers to be closer to facilities and/or facilitate access to timely referral and transportation.

Goal  
3

Target 3.2

**Target 3.2:** By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births

Indicator 3.2.1: Under-5 mortality rate

Current situation

- The under-5 mortality rate in the Region decreased from 60 deaths per 1000 live births in 2010 to 52 deaths per 1000 live births in 2015, then 45 deaths per 1000 live births in 2021.
- In 2021, under-5 mortality in 16 countries of the Region was equal or lower than the SDG target of less than 25 deaths per 1000 live births with similar rates between males and females; in half of these countries (Qatar, United Arab Emirates,

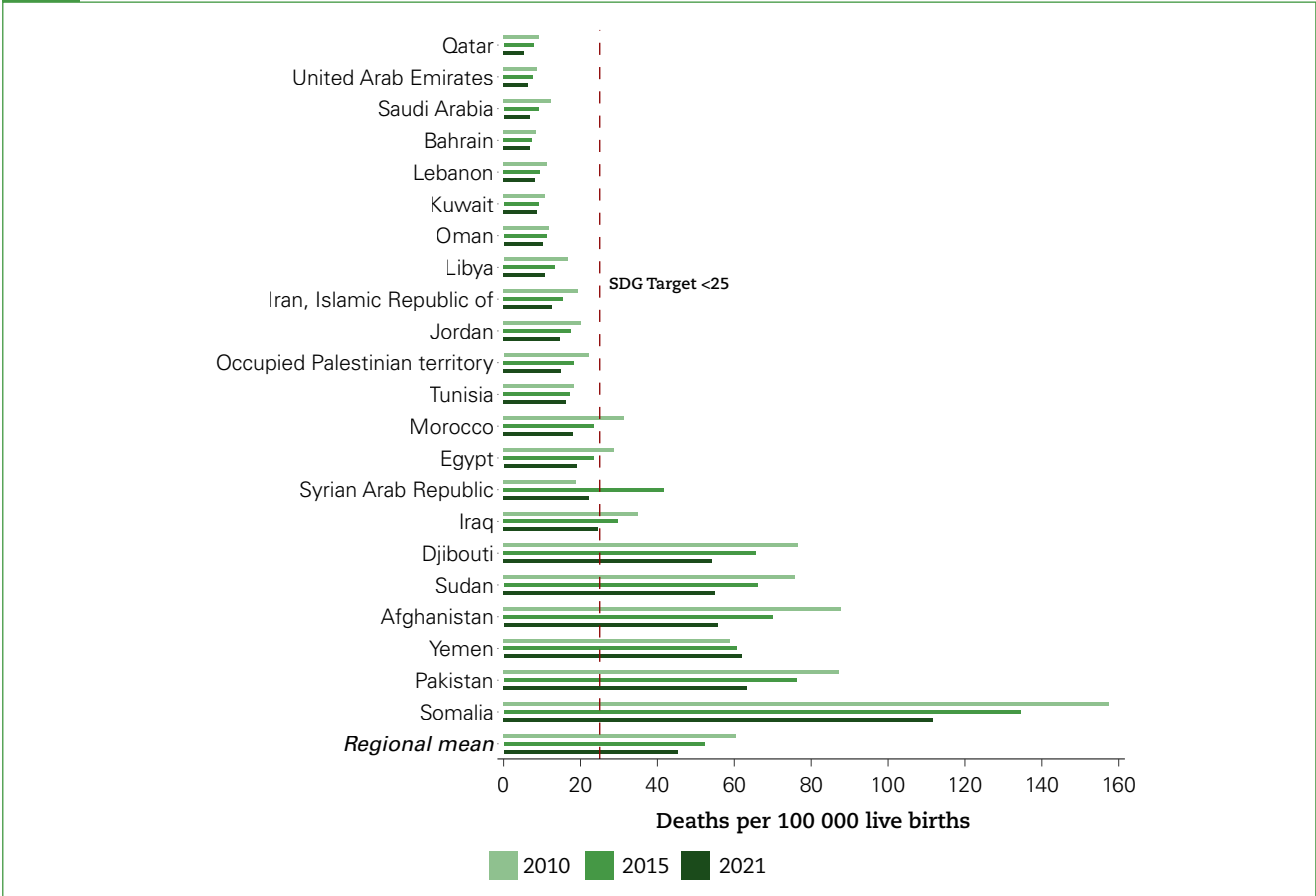
Saudi Arabia, Bahrain, Lebanon, Kuwait, Oman and Libya) it was lower than 12 deaths per 1000 live births, half of the SDG target.

- In 2021, under-5 mortality in six countries (Djibouti, Sudan, Afghanistan, Yemen, Pakistan and Somalia) exceeded 50 deaths per 1000 live births, more than double the SDG target of less than 25 deaths per 1000 live births.
- In Yemen there was a continuing increase in under-5 mortality between 2010 and 2021 while in Syria, there was an increase between 2010 and 2015 followed by a decrease between 2015 and 2021 – although the level in 2021 was still higher than 2010.

Key message

- Countries off-track in under-5 mortality reduction need to scale up evidence-based, high-impact interventions based on their context, including in humanitarian settings while countries with good progress need to emphasize addressing inequities and improving quality of care.

3.2.1 Under-5 mortality rate, 2010–2021



### Challenges

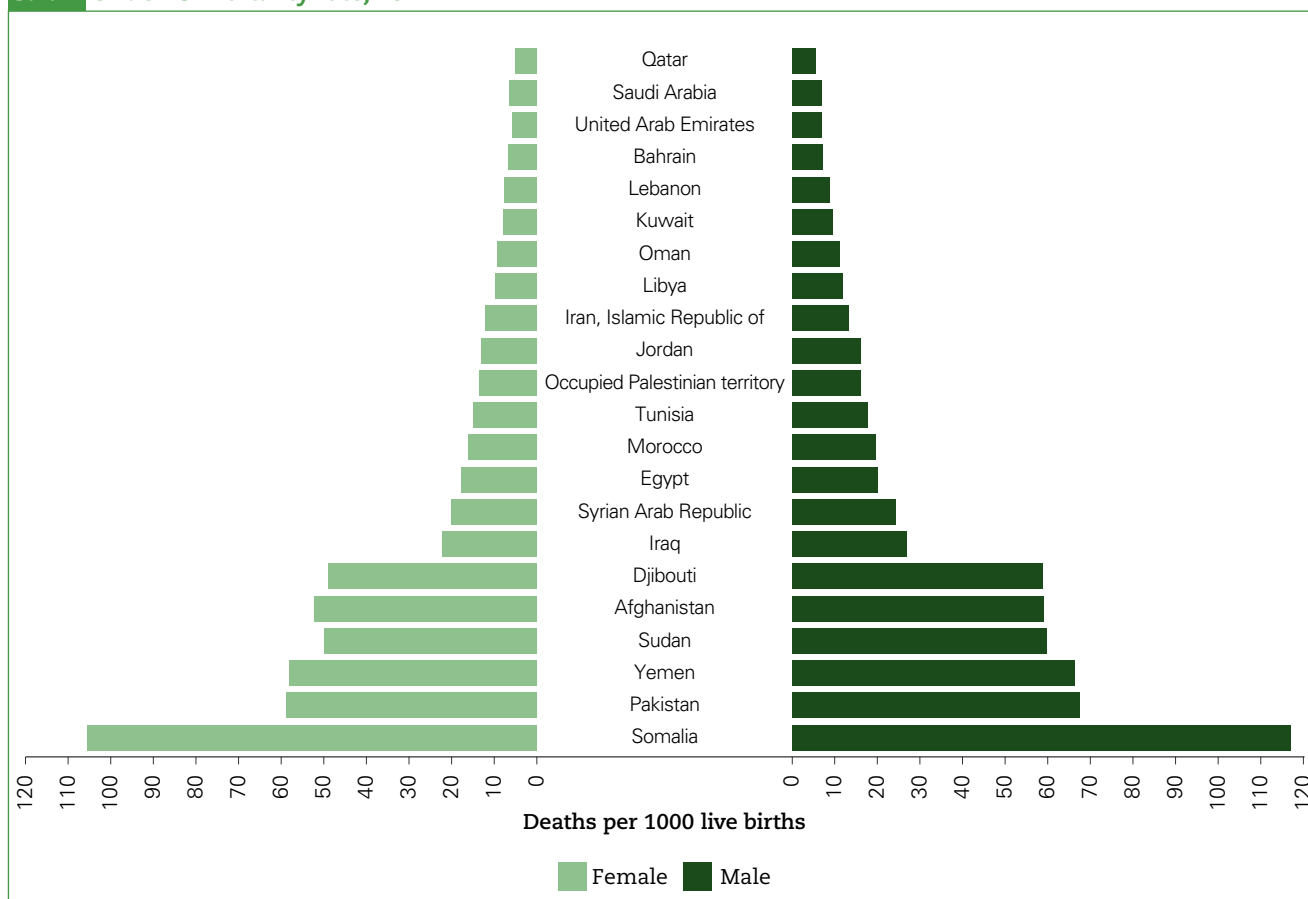
- The indirect impact of the COVID-19 pandemic on essential maternal, neonatal, child and adolescent health services.
- The shortage of updated reliable national data – on mortality including cause of death, on morbidity, on risk factors and on coverage of interventions – to inform policy.
- The fragmentation and verticality of child health programmes at country level.
- The scarcity of financial resources for child health interventions, particularly from domestic funds.
- Weak national capacities in planning, implementation, and monitoring and evaluation of child health programmes.

### Steps for accelerated action

- Apply multisectoral child-centred interventions along the life-course.

- Strengthen/scale up the quality of child health-care services at each level of the health system (community, primary health care and referral) through the provision of child-friendly health facilities and services, and the availability of child-specific appropriate equipment and appropriately trained and competent staff.
- Build up the capacity of health-care providers to deliver quality child health and development services.
- Build national capacities in managing reproductive, maternal, neonatal, child and adolescent health programmes at national and subnational levels, both in stable and humanitarian settings.
- Strengthen community engagement and empower families to care for and protect their children.
- Invest in digital solutions in the areas of patient care, disease surveillance, monitoring, prevention and e-learning for health worker decision support to improve child health services.

#### 3.2.1 Under-5 mortality rate, 2021



### Available guidance/tools

- WHO Regional Committee for the Eastern Mediterranean. Regional implementation framework on ending preventable newborn, child and adolescent deaths and improving health and development. 2019 ([https://applications.emro.who.int/docs/RC\\_Technical\\_Papers\\_2019\\_3\\_en.pdf?ua=1](https://applications.emro.who.int/docs/RC_Technical_Papers_2019_3_en.pdf?ua=1))
- Child and adolescent health in humanitarian settings operational guide: a holistic approach for programme managers [in press]; following publication will be posted at: <https://www.emro.who.int/child-adolescent-health/child-health/information-resources.html>
- WHO Regional Office for the Eastern Mediterranean. Child and adolescent health [webpage] (<http://www.emro.who.int/entity/child-adolescent-health/home.html>)
- WHO. Nurturing care for early childhood development. A framework for helping children survive and thrive to transform health and human potential [guideline]. 2018 (<https://www.who.int/publications/i/item/9789241514064>)
- WHO. The global strategy for women's, children's and adolescents' health (2016–2030) ([https://www.who.int/docs/default-source/child-health/the-global-strategy-for-women-s-children-s-and-adolescents-health-2016-2030.pdf?sfvrsn=f1dbd6f9\\_4](https://www.who.int/docs/default-source/child-health/the-global-strategy-for-women-s-children-s-and-adolescents-health-2016-2030.pdf?sfvrsn=f1dbd6f9_4))

- WHO. Standards for improving the quality of care for children and young adolescents in health facilities (<https://www.who.int/publications/item/9789241565554>)
- Country profiles. Child and Adolescent Health. WHO Regional Committee for the Eastern Mediterranean (<https://www.emro.who.int/child-adolescent-health/data-statistics/country-profiles.html>)

### Key references

- Levels and trends in child mortality. Report 2022: Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2022 (<https://childmortality.org/wp-content/uploads/2023/01/UN-IGME-Child-Mortality-Report-2022.pdf>)
- Stillbirth and Child Mortality Estimates [online database]. New York: IGME: UN Inter-agency Group for Child Mortality Estimation (<https://childmortality.org/>)

### Data sources

#### Under-5 mortality:

- <https://childmortality.org/data>
- [https://www.who.int/data/gho/data/themes/topics/sdg-target-3\\_2-newborn-and-child-mortality](https://www.who.int/data/gho/data/themes/topics/sdg-target-3_2-newborn-and-child-mortality)

**Indicator 3.2.2: Neonatal mortality rate**

**Current situation**

- The neonatal mortality rate in the Region decreased from 32 deaths per 1000 live births in 2010 to 28 deaths per 1000 live births in 2015 and 25 deaths per 1000 live births in 2021.
- Between 2010 and 2021, most countries in the Region experienced reductions in their neonatal mortality rate – Egypt, Islamic Republic of Iran, Libya, Morocco and Saudi Arabia by one third or more; however, the Syrian Arab Republic experienced an increase of 7.3% and in Yemen it stalled.
- In 2021, neonatal mortality in 15 countries of the Region was within the SDG target of equal or less than 12 deaths per 1000 live births. However, in seven countries (Iraq, Sudan, Yemen, Djibouti, Somalia, Afghanistan and Pakistan) the rate

exceeded 24 deaths per 1000 live births, more than double the SDG target.

- In 2021, neonatal mortality in 14 countries of the Region constituted more than 50% of the under-5 mortality.

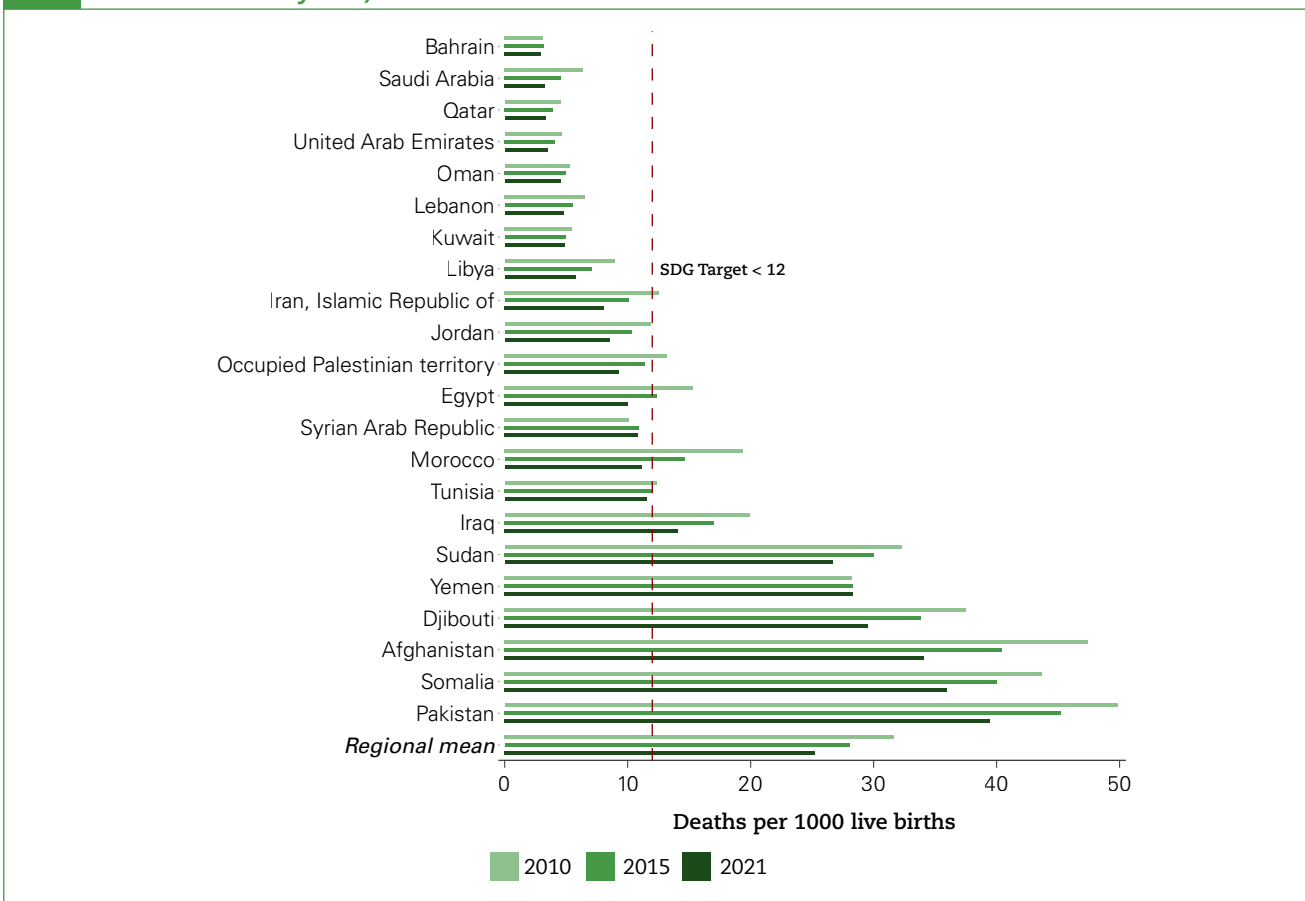
**Key message**

- Countries off-track in under-5 mortality reduction need to scale up evidence-based, high-impact interventions based on their context, including in humanitarian settings while countries with good progress need to emphasize addressing inequities and improving quality of care.

**Challenges**

- Newborn health programmes are fragmented between maternal and child health structures at country level, with weak collaboration between different related programmes.

**3.2.2 Neonatal mortality rate, 2010–2021**



- Security and instability are key challenges.
- Quality of care is inadequate, with adherence to WHO recommendations and guidelines not up to the desired level.
- Scarcity of financial resources for newborn health interventions, particularly from domestic funds.
- Weak national capacities in planning, implementation, and monitoring and evaluation of child health programmes.
- Lack of routine collection for information systems of the detailed data required to understand and address newborn health issues.

### Steps for accelerated action

- Ensure political commitment to achieve targets and track financial contributions to newborn health.
- Prioritize newborn health interventions in national strategies and plans in line with the global Every Newborn Action Plan (see below) for ending preventable newborn mortality and stillbirth.
- Invest in improving the quality of maternal and newborn care around the time of birth at facility and community levels.
- Strengthen monitoring and measurement capacities for newborn health indicators, such as the number of newborn and maternal deaths and stillbirths.
- Invest in strengthening accountability and partnership and promote equity.
- Support newborn health care during emergencies.
- Strengthen family knowledge and skills to promote and improve home care for newborns as well as community engagement.

### Available guidance/tools

- WHO. Regional Office for the Eastern Mediterranean. Regional implementation framework on ending preventable newborn, child and adolescent deaths and improving health and development. 2019 (<https://apps.who.int/iris/handle/10665/371139>)
- WHO, UNICEF. Every newborn. An action plan to end preventable deaths. 2014 (<https://www.who.int/initiatives/every-newborn-action-plan#:~:text=The%20global%20Every%20Newborn%20Action,reducing%20maternal%20mortality%20and%20morbidity>)

- WHO. The global strategy for women's, children's and adolescents' health (2016–2030) ([https://www.who.int/docs/default-source/child-health/the-global-strategy-for-women-s-children-s-and-adolescents-health-2016-2030.pdf?sfvrsn=f1dbd6f9\\_4](https://www.who.int/docs/default-source/child-health/the-global-strategy-for-women-s-children-s-and-adolescents-health-2016-2030.pdf?sfvrsn=f1dbd6f9_4))
- Early essential newborn care: clinical practice pocket guide, 2nd edition. WHO; 2022 (<https://www.who.int/publications/i/item/9789290619659>)
- Standards for improving quality of maternal and newborn care in health facilities. WHO; 2016 (<https://www.who.int/publications/i/item/9789241511216>)
- Newborn health in humanitarian settings. Field guide. UNICEF and Save The Children. 2018 (<https://www.unicef.org/media/61561/file>)
- Standards for improving the quality of care for small and sick newborns in health facilities. WHO; 2020 (<https://www.who.int/publications/i/item/9789240010765>)
- Improving maternal and newborn health and survival and reducing stillbirth. Progress report 2023. WHO (<https://www.who.int/publications/i/item/9789240073678>)

### Key references

- Levels and trends in child mortality. Report 2022: Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2022 (<https://childmortality.org/wp-content/uploads/2023/01/UN-IGME-Child-Mortality-Report-2022.pdf>)
- Country profiles. Child and Adolescent Health. WHO Regional Committee for the Eastern Mediterranean (<https://www.emro.who.int/child-adolescent-health/data-statistics/country-profiles.html>)

### Data sources

#### Neonatal mortality:

- Stillbirth and Child Mortality Estimates [online database]. New York: IGME: UN Inter-agency Group for Child Mortality Estimation (<https://childmortality.org/>)
- WHO Global Health Observatory. ([https://www.who.int/data/gho/data/themes/topics/sdg-target-3\\_2-newborn-and-child-mortality](https://www.who.int/data/gho/data/themes/topics/sdg-target-3_2-newborn-and-child-mortality))



**Target 3.3:** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases

**Indicator 3.3.1: Number of new HIV infections per 1000 uninfected population, by sex, age and key populations**

**Current situation**

- By end of 2021, there were an estimated 430 000 people living with HIV (PLHIV) in the Region, including 14 000 children. This represents 1% of the global HIV burden.
- In 2021, WHO and UNAIDS estimated the number of new HIV infections in the Region at 42 000 with 19 000 deaths attributed to HIV-related causes, equivalent to a 40% increase in estimated new

HIV infections and a 58% increase in AIDS-related deaths compared with 2010.

- The epidemic in the Region mostly affects people aged under 25 (75% of total HIV cases), and data indicate a male to female ratio of two to one.
- Out of the estimated 430 000 PLHIV, 41% are diagnosed, 27% are on treatment and 24% are virally suppressed.

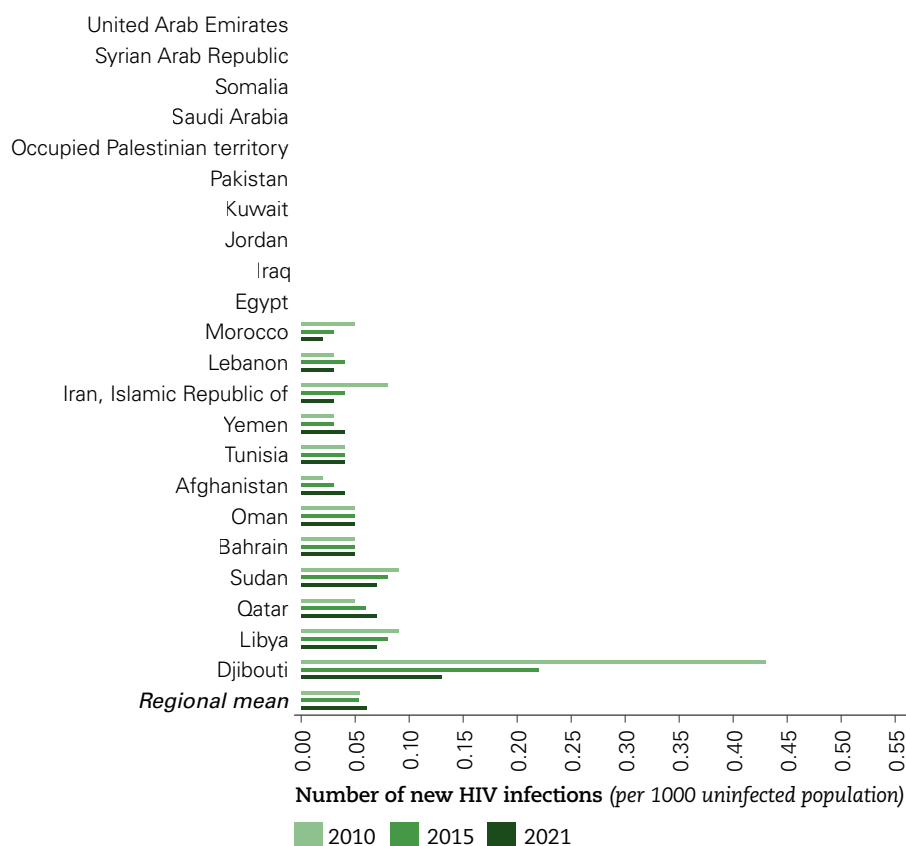
**Key message**

- Since the HIV epidemic is concentrated in certain populations, maximize access to good quality health services in supportive environments free of stigma and discrimination by diversifying testing approaches and adopting differentiated service delivery models.

**Challenges**

- The HIV epidemic is concentrated in key populations who are highly stigmatized and face discrimination that affects their access to HIV services.

**3.3.1 Number of new HIV infections (per 1000 uninfected population), 2010–2021**



- Most of the countries in the Region missed the interim targets for 2020 to identify 90% of the total HIV population, treat 90% of those who are diagnosed, and achieve 90% viral load suppression among those on treatment.
- COVID-19 disrupted some of the progress made by countries towards achieving the global targets.
- Low coverage of HIV treatment with antiretrovirals (24%) due to low HIV testing coverage among key populations, with most HIV testing occurring among low-prevalence groups.
- Late diagnosis is a persistent challenge in the Region.
- In most countries of the Region, the HIV response is largely dependent on external donor funding, which may reflect the limited political commitment and low priority given to HIV.
- Civil unrest and emergencies in some countries.
- Lack of data that accurately describe the burden and service coverage among key populations.

### Steps for accelerated action

- Strengthen political commitment and ensure supportive health-care environments (free of stigma and discrimination), particularly for the most at-risk populations.
- Engage civil society organizations more in providing health services for key populations and PLHIV on an appropriate scale.
- Countries should improve and diversify their testing approaches and introduce innovative techniques such as HIV self-testing. This would help more people to become aware of their status, close the diagnosis gap and accordingly link more people to care and treatment.
- Countries should adopt differentiated service delivery models to maximize access to services for key populations, with good quality of care and treatment provided. This would include integration of the services provided for HIV, hepatitis and sexually-transmitted infections, since these services are provided to the same target groups.

- More focus on data generation, for example through strengthening of HIV/AIDS surveillance activities, including more frequent integrated biological and behavioural surveillance surveys.

### Available guidance/tools

- Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030 (GHSS). WHO; 2022 (<https://www.who.int/publications/item/9789240053779>)
- Regional action plan for the implementation of the global health sector strategy on HIV, hepatitis and STIs 2022–2030 (<https://apps.who.int/iris/handle/10665/365853>)

### Key references

- Global Health Sector Strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030 (GHSS). WHO; 2022 (<https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/strategies/global-health-sector-strategies>)
- Progress report on HIV, viral hepatitis and sexually transmitted infections, 2019. Accountability for the global health sector strategies, 2016–2021. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/item/progress-report-on-hiv-viral-hepatitis-and-sexually-transmitted-infections-2019>)
- Mugisa B, Sabry A, Hutin Y, Hermez J. HIV epidemiology in the WHO Eastern Mediterranean region: a multicountry programme review. *Lancet HIV*. 2022 Feb;9(2):e112–e119. Doi: 10.1016/S2352-3018(21)00320-9. PMID: 35120632.

### Data sources

- AIDSinfo. Global data on HIV epidemiology and response [indicator registry]. (<https://aidsinfo.unaids.org/>)

**Indicator 3.3.2: Tuberculosis incidence per 100 000 population**

**Current situation**

- In 2021, the incidence of tuberculosis (TB) in the Region was 112 per 100 000 population, the third highest among the six WHO regions and lower than the estimated global incidence of 134 per 100 000 population.
- Although the regional decline in the estimated TB incidence between 2015 and 2021 was only 5.4%, far short of the End TB Strategy 2020 milestone of a 20% reduction – and incidence increased in Libya, Qatar and United Arab Emirates – the decline surpassed the global target for this timeframe in Djibouti, Egypt, Islamic Republic of Iran, Iraq, Saudi Arabia and Sudan.
- In 2021, the estimated incidence of TB varied across the Region from less than 1 per 100 000 population in the United Arab Emirates and

the West Bank and Gaza to more than 250 per 100 000 population in Pakistan (264 per 100 000 population) and Somalia (250 per 100 000 population).

- In 2021, the estimated incidence of TB was under 20 per 100 000 population in 11 countries of the Region that are on track to eliminate TB by 2030.

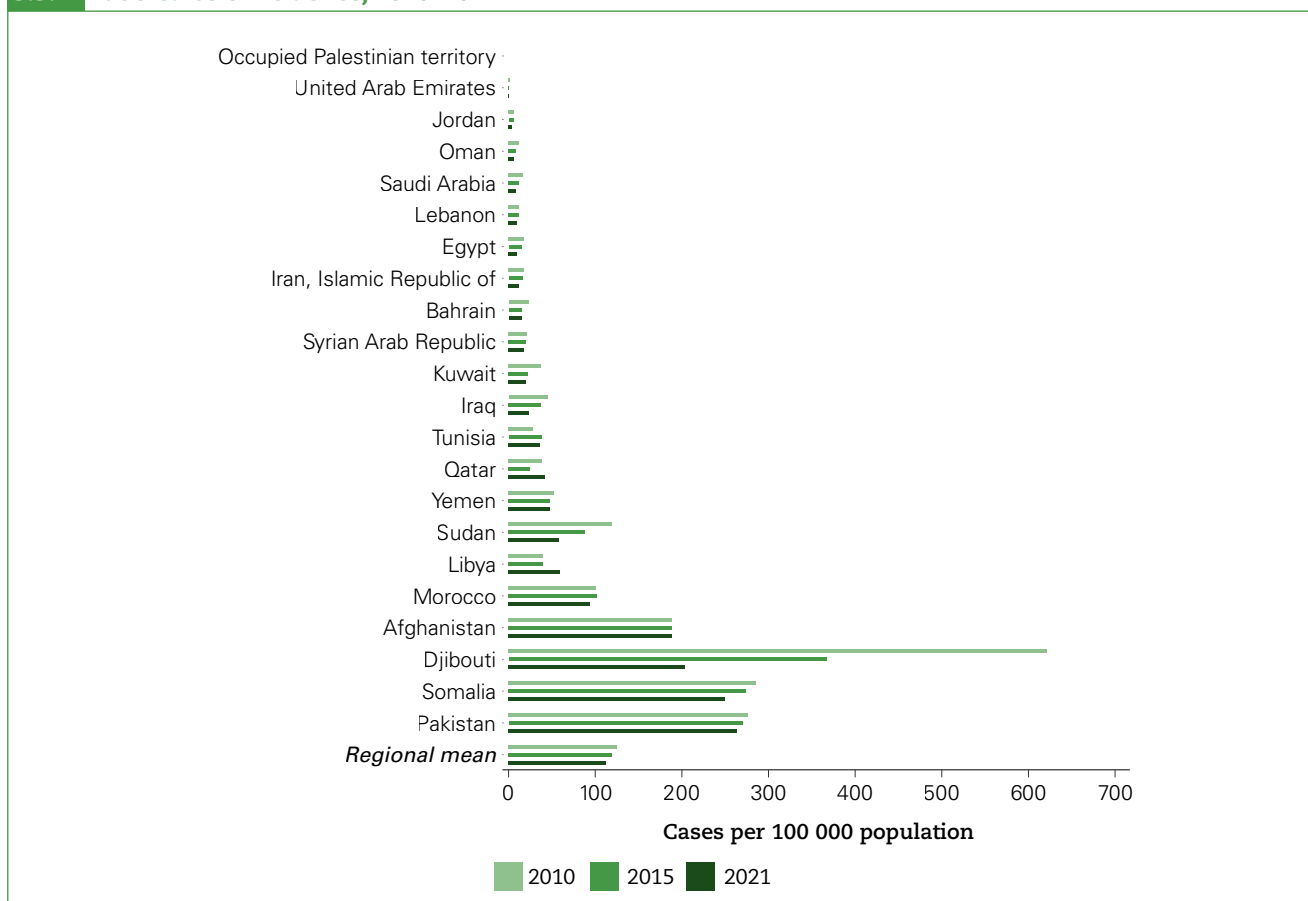
**Key message**

- Expand coverage of quality TB services across all sectors. Integrate and strengthen TB services within primary health care to ensure systematic screening, early diagnosis and standardized quality of care focusing on at-risk groups and settings, using the latest diagnostics and medicines to advance TB elimination in the Region.

**Challenges**

- Resources for TB programme implementation are limited, with insufficient funding for TB care, prevention and control from domestic sources.

**3.3.2 Tuberculosis incidence, 2010–2021**



- TB services are not fully integrated in primary health-care facilities in any country in the Region, and referral systems are not fully functional.
- 42% of drug-sensitive TB cases remain undiagnosed or unnotified to national TB programmes despite a full recovery of case notifications in 2021 to at least pre-pandemic levels. More than 80% of estimated drug-resistant TB cases in the Region are not on treatment.
- While the number of people starting TB preventive treatment increased by 17% between 2020 and 2021, coverage of preventive treatment remains low. Only 18% of people living with HIV and 21% of children under 5 who were contacts of TB patients benefitted from such treatment.
- Health risk factors and determinants drive the TB epidemic. Undernourishment is the leading contributor to the TB epidemic in the Region. Addressing such risk factors and determinants at country level is therefore essential to end TB. At the moment, such efforts are lacking.
- Multisectoral, people-centred, holistic approaches to end TB remain limited in some countries of the Region.
- contacts of individuals with TB, people living with HIV or other co-morbidities, people in prisons and other penitentiary institutions, and urban areas.
- Scale up the programmatic management of drug-resistant TB by further decentralizing services and accelerating the introduction of the new, shorter all-oral treatment regimens.
- Enhance and sustain the programmatic and managerial capacities of national TB programmes.
- Ensure continued support to advance TB elimination in low-burden countries.
- Ensure continuation of TB programme activities during complex emergencies.
- Promote TB research and innovation.

#### Available guidance/tools

#### Steps for accelerated action

- Increase domestic funding for TB and increase the efficiency of funding allocation and spending.
- Seek cross-programmatic efficiency gains by strengthening health systems and adopting a multisectoral approach.
- Integrate and strengthen TB services within primary health care to ensure early diagnosis, systematic screening of contacts and at-risk groups, and standardized quality care for all, including for drug-resistant TB.
- Introduce and expand the use of new TB diagnostic technologies and tools (molecular diagnostic tests, chest X-ray, computer-aided detection software).
- Ensure universal access to TB services by providing quality service coverage across all sectors. This will require further integration of TB services in primary health-care facilities and the involvement of all health-care providers, especially the private sector, civil society organizations and communities in high-priority countries.
- Strengthen TB services focusing on at-risk groups and settings, including household and other close
- Implementing the End TB Strategy: the essentials. Geneva: World Health Organization; 2015 (<https://www.who.int/publications/i/item/9789240065093>)
- Global tuberculosis report 2022. Geneva: World Health Organization; 2022 (<https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2022>)
- WHO TB knowledge sharing platform: access the modular WHO guidelines on tuberculosis and handbooks (<https://www.tbksp.org/en>)
- WHO TB guidelines: recent updates (<https://www.who.int/publications/digital/global-tuberculosis-report-2021/featured-topics/tb-guidelines>)
- Framework for collaborative action on tuberculosis and comorbidities. WHO; 2022 (<https://www.who.int/publications/i/item/9789240055056>)
- Towards tuberculosis elimination: an action framework in low-incidence countries. WHO; 2014 (<https://www.who.int/publications/i/item/9789241507707>)
- Incidence of tuberculosis (per 100 000 population per year) [online database]. WHO Global Health Observatory ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/incidence-of-tuberculosis-\(per-100-000-population-per-year\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/incidence-of-tuberculosis-(per-100-000-population-per-year)))
- Global tuberculosis report 2022. Geneva: World Health Organization; 2022 (<https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2022>)

#### Data sources

**Indicator 3.3.3: Malaria incidence per 1000 population at risk**

**Current situation**

- Fourteen countries in the Region are free of malaria (zero indigenous cases reported for more than three consecutive years).
- Six countries (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen) account for more than 99% of confirmed malaria cases in the Region.
- The estimated incidence in Djibouti, Somalia and Sudan increased over the period 2010–2021. In Djibouti, the increase in recent years has been alarming, particularly during the period 2018–2021 due to population movement from neighbouring countries, the presence of invasive *Anopheles stephensi* and an inefficient control programme.

- In 2021, Djibouti and Sudan had the highest estimated incidence of malaria in the Region at 70.5 and 72.8 cases per 1000 population, respectively.

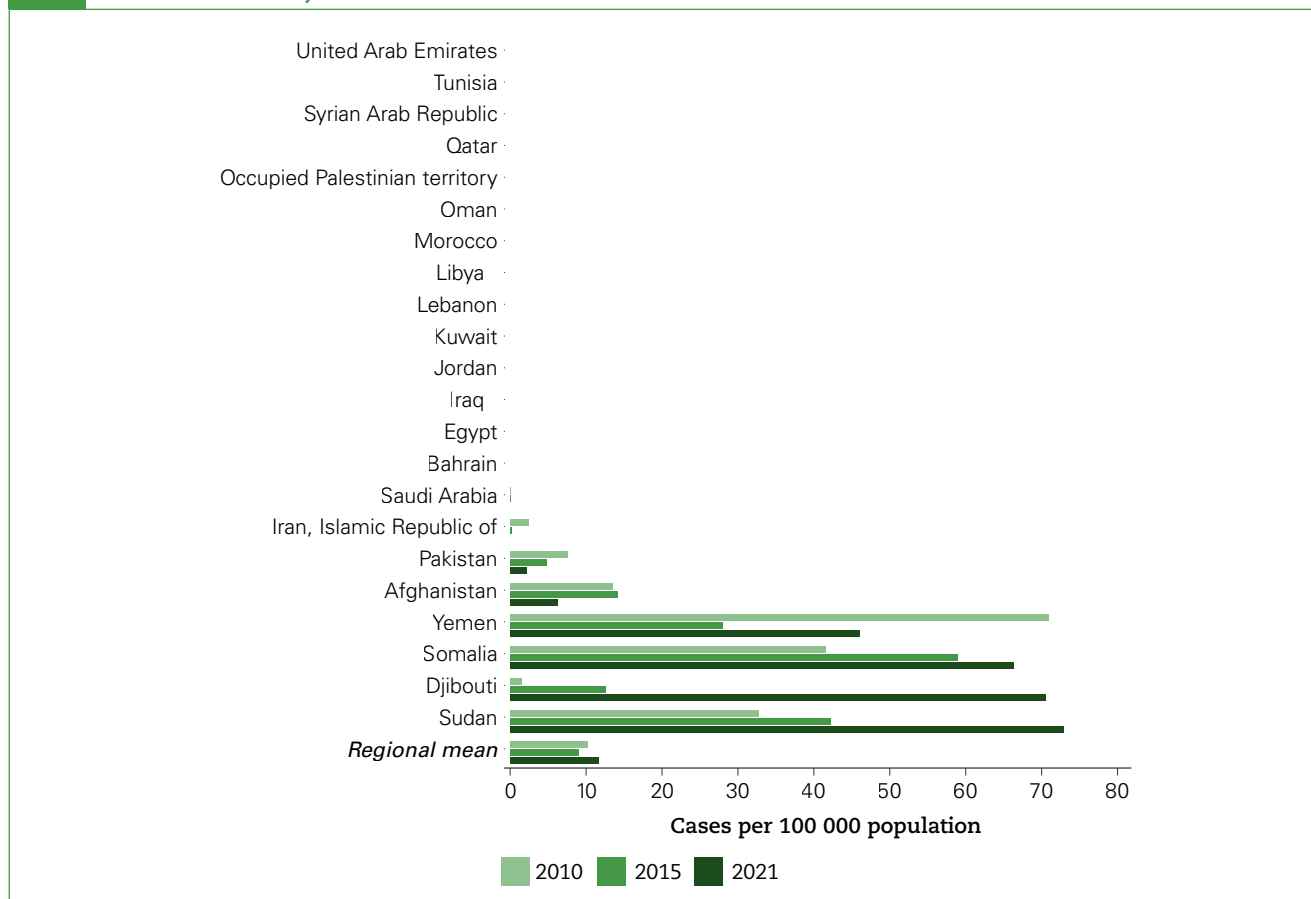
**Key message**

- Promote an integrated multisectoral approach to the prevention and control of vector-borne diseases including introducing latest evidence-based interventions appropriate for the local context to advance toward malaria elimination in malaria-endemic countries of the Region.

**Challenges**

- Political unrest and instability in the Region have led to the displacement of populations and interrupted health service provision in the context of already weak health systems.
- The emergence of other vector-borne diseases, such as dengue and chikungunya, in malaria-endemic countries.

**3.3.3 Malaria incidence, 2010–2021**



Note: Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, occupied Palestinian territory, Oman, Qatar, Syrian Arab Republic, Tunisia and United Arab Emirates are considered malaria-free. Islamic Republic of Iran and Saudi Arabia reported no cases of indigenous transmission in 2021.

- Lack of sustained domestic financing and high levels of dependency on external funding for malaria control.
- Significant reduction in quality human resources capacity to deal with vector-borne diseases.
- Weak health systems including surveillance and health information systems with resulting lack of timely and quality data, which compromises the ability to adjust malaria interventions according to changes in disease burden.
- Environmental changes, global warming and unplanned urbanization.
- Invasive vectors and emergence of histidine-rich protein 2 and 3 gene deletions, insecticide resistance and risk of antimalarial drug resistance.

### Steps for accelerated action

- For endemic countries, intensify collaboration with partners to increase investment and optimize use of resources with tailoring of interventions, including new interventions such as malaria vaccines, where suitable, for maximum impact based on available data.
- Increase domestic and non-domestic funding oriented towards an integrated programme for malaria and other vector-borne diseases. Develop the capacity of local health staff for the integrated control of vector-borne diseases.
- In countries experiencing humanitarian emergencies, ensure that programme capacity is sustained for the continuity of interventions with the involvement of all stakeholders.
- Promote strong community participation and establish partnerships between the public and private sectors as part of a multisectoral approach to ensure a sustainable path towards burden reduction and malaria elimination.

### Available guidance/tools

- Global technical strategy for malaria 2016–2030. WHO; 2015 (<https://www.who.int/publications/i/item/9789241564991>)
- Regional malaria action plan 2022–2030: towards a malaria-free Region. WHO Regional Office for the Eastern Mediterranean; 2017 ([http://applications.emro.who.int/docs/EMROPUB\\_2017\\_EN\\_19546.pdf?ua=1](http://applications.emro.who.int/docs/EMROPUB_2017_EN_19546.pdf?ua=1))
- Regional plan of action 2019–2023 for implementation of the Global vector control response 2017–2030. WHO Regional Office for the Eastern Mediterranean; 2019 ([http://applications.emro.who.int/docs/EMROPub\\_2019\\_EN\\_23552.pdf?ua=1&ua=1](http://applications.emro.who.int/docs/EMROPub_2019_EN_23552.pdf?ua=1&ua=1))
- Malaria surveillance, monitoring & evaluation: a reference manual. WHO; 2018 (<https://www.who.int/publications/i/item/9789241565578>)
- A framework for malaria elimination. WHO; 2017 (<https://www.who.int/publications/i/item/9789241511988>)
- Tailoring malaria interventions in the COVID-19 response. WHO; 2020 (<https://www.who.int/publications/m/item/tailoring-malaria-interventions-in-the-covid-19-response>)

### Key references

- World malaria report 2022. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO (<https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2022>)

### Data sources

- World malaria report 2022. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO (<https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2022>)

**Indicator 3.3.4: Hepatitis B incidence per 100 000 population**

**Current situation**

- In 2020, prevalence of hepatitis B surface antigen (HbsAg) among children under 5 years of age in the Region was 0.8%, compared to 1.6% in 2017. Therefore, the Region achieved the hepatitis B control target of 1% or less prevalence for 2020.
- The proportion of persons with hepatitis C infection diagnosed was 35% in 2020 compared to 18% in 2015 and the proportion of those diagnosed with hepatitis C who had started on treatment reached 33% in 2020 compared to 12% in 2015. The progress on hepatitis C testing and treatment is mainly driven by Egypt's efforts to eliminate the disease.
- For hepatitis B, in 2020, 14% of infected persons were diagnosed and 2% were on treatment out of the estimated 18 million compared with 2% diagnosed and less than 1% on treatment in 2015.

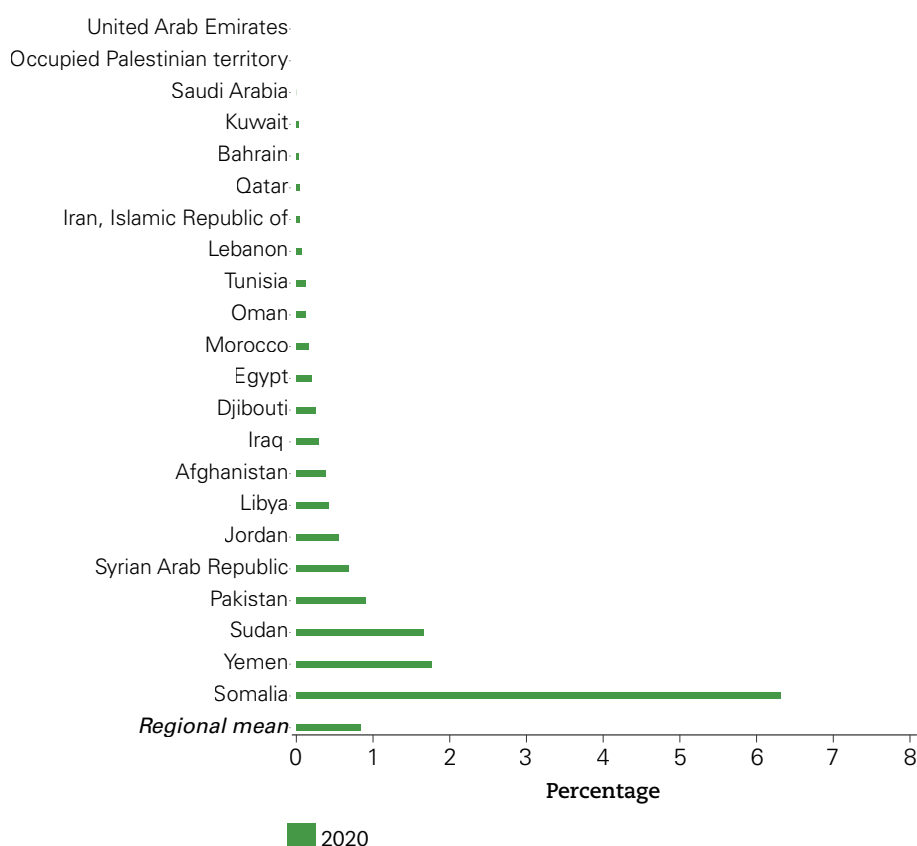
**Key message**

- Invest and implement hepatitis B elimination plans including a comprehensive immunization programme focusing on infants, children and people at increased risk and expanding access to hepatitis diagnostic and treatment services in line with viral hepatitis elimination policies and strategies.

**Challenges**

- Hepatitis is not high on the public health agenda in some countries, and this is reflected in the non-availability of resources for a national response.
- The Eastern Mediterranean countries have established governance mechanisms, policies and strategies towards viral hepatitis elimination. However, implementation remains poor with insufficient financing.
- Lack of data accurately describing the trends and epidemic burden in some countries, especially among key populations such as injecting drug users.

**3.3.4 Hepatitis B surface antigen (HBsAg) prevalence among children under 5, 2020**



### Goal 3

- Harm reduction services remain very limited in the Region. The number of syringes per person who injects drugs was only 27 per year in 2020, leaving a major gap to reach the 200 per year target for 2030.
- In some countries of the Region, a proportion of births still occur outside a health facility, making it challenging to ensure hepatitis vaccination of all newborns.
- Coverage of hepatitis B vaccine birth dose is very low (33% in 2022) compared to the global elimination target (90%).
- Very limited testing and treatment interventions.
- Expense of diagnostic tools needed for hepatitis diagnosis.
- Weak involvement of civil society.

#### Steps for accelerated action

- Develop costed national strategies in view of the elimination agenda and allocate resources for implementation.
- Expand access to hepatitis services along the cascade (diagnosis, treatment and cure).
- Advocate with decision-makers to introduce or scale up hepatitis B birth dose and third dose nationwide in countries with low coverage.
- Implement a comprehensive hepatitis B virus immunization programme, including catch-up hepatitis B virus vaccination for children or adolescents with low coverage and offer hepatitis B virus vaccination to people at increased risk of acquiring and transmitting the virus.
- Expand birth dose vaccination and improve hepatitis testing among pregnant women.

- Introduce and expand harm reduction services.
- Strengthen data generation and systems to monitor the progress.

#### Available guidance/tools

- Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030 (GHSS). WHO; 2022 (<https://www.who.int/publications/item/9789240053779>)
- Regional action plan for the implementation of the global health sector strategies on HIV, hepatitis and sexually transmitted infections 2022–2030. WHO Regional Office for the Eastern Mediterranean; 2022 (<https://apps.who.int/iris/handle/10665/365853>)

#### Key references

- Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2021. Accountability for the global health sector strategies, 2016–2021. Geneva: WHO; 2021 (<https://www.who.int/publications/item/9789240027077>)

#### Data sources

- WHO Global Health Observatory. Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hepatitis-b-surface-antigen-\(hbsag\)-prevalence-among-children-under-5-years](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hepatitis-b-surface-antigen-(hbsag)-prevalence-among-children-under-5-years))
- WHO Hepatitis B Vaccine country profiles. WHO chronic HBV infections (prevalence of HBsAg) dashboard (<https://whohbsagdashboard.surge.sh/#hbv-country-profiles>)



**Indicator 3.3.5: Number of people requiring interventions against neglected tropical diseases**

**Current situation**

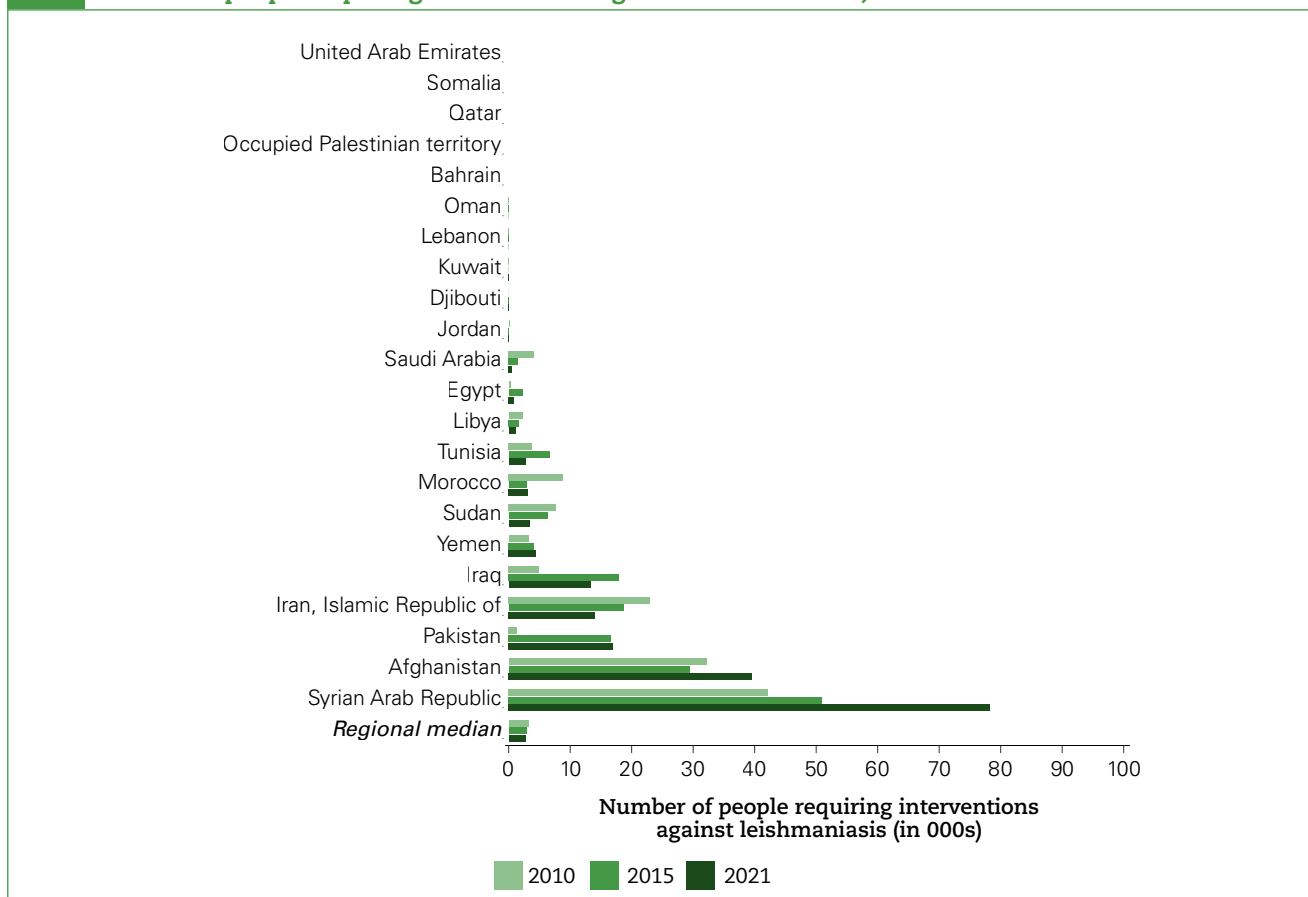
- Neglected tropical diseases are a major public health problem in the Region, with at least one such disease prevalent in all countries. The main neglected tropical diseases are dengue, leishmaniasis, leprosy, onchocerciasis, rabies, schistosomiasis, soil-transmitted helminthiasis and trachoma.
- Globally, this Region has the highest cutaneous leishmaniasis burden, with 174 920 cases reported in 2021 (79% of the global burden).
- In 2021, 93% of the cutaneous leishmaniasis cases reported in the Region were in the Syrian Arab Republic, Afghanistan, Pakistan, Islamic Republic of Iran and Iraq.
- In 2021, 4660 cases of visceral leishmaniasis were reported, with 71% of these cases occurring in Sudan.

- There is wide variation in the number of leishmaniasis cases among countries in the Region. In 2021, the total reported number of leishmaniasis cases (both cutaneous and visceral) in the Region ranged from zero cases in Lebanon and Oman to 78 231 cases in the Syrian Arab Republic.
- Some countries have shown an increase in the number of cases (e.g. Syria Arab Republic and Afghanistan) and other countries have reported a reduction (e.g. Islamic Republic of Iran, Iraq and Tunisia) in leishmaniasis cases in 2021 compared to 2015.

**Key message**

- Strengthen integrated surveillance of neglected tropical diseases and increase access to early diagnosis and prompt treatment to end the burden of guinea worm disease, leprosy, lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma in the Region; control the burden of dengue, foodborne diseases and leishmaniasis.

**3.3.5 Number of people requiring interventions against leishmaniasis, 2010–2021**



Note: The figure includes both cutaneous and visceral leishmaniasis.

### Challenges

- Poor access to early diagnosis and effective prompt treatment for cutaneous leishmaniasis and dengue.
- Shortage of suppliers in the global market of effective medicines for leishmaniasis.
- Insufficient implementation of vector and animal reservoir host control interventions (against sandflies for cutaneous leishmaniasis and mosquitoes for dengue, for example).
- Lack of donor support.
- Frequent population migration due to emergencies and conflict.
- Stigma associated with these diseases (for example, cutaneous leishmaniasis and leprosy).

### Steps for accelerated action

- Increase access to early diagnosis and treatment by decentralizing case management to the primary health care level.
- Raise community awareness of the need for early treatment-seeking behaviour.
- Address stigma through community engagement.

- Mobilize resources, partner support and communities to strengthen vector and reservoir host control.
- Strengthen integrated surveillance to prevent outbreaks, monitor disease burden and assess the impact of control measures.

### Available guidance/tools

- Leishmaniasis fact sheet. WHO (<https://www.who.int/news-room/fact-sheets/detail/leishmaniasis>)
- Control of leishmaniasis. World Health Assembly Resolution WHA60.13 (<https://www.who.int/publications/i/item/wha60.13>)

### Data sources

- WHO Global Health Observatory. Cutaneous leishmaniasis (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/number-of-cases-of-cutaneous-leishmaniasis-reported>)
- WHO Global Health Observatory. Visceral leishmaniasis (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/number-of-cases-of-visceral-leishmaniasis-reported>)

**Target 3.4:** By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being

**Indicator 3.4.1: Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease**

**Current situation**

- Between 2010 and 2019, the probability of dying between exact ages 30 and 70 from any of the four main NCDs (cardiovascular disease, cancer, diabetes or chronic respiratory disease) in the Region decreased from 27% in 2010 to 26% in 2015 and to 25% in 2019. These values were the highest in all three years of any WHO region.
- In 2019, the probability of dying between exact ages 30 and 70 from any of the four main NCDs in

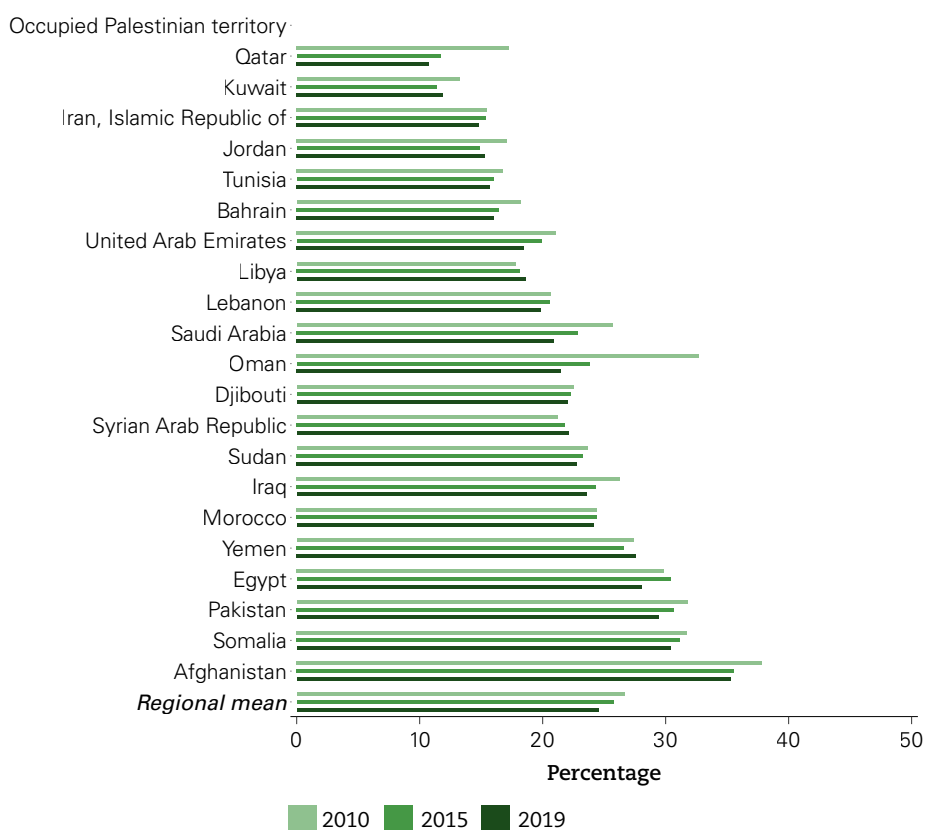
the Region was lowest in Qatar (11%) and highest in Afghanistan (35%).

- Although a decline of 15% in the probability of premature mortality from NCDs or more was estimated for Oman, Qatar and Saudi Arabia between 2010 and 2019, there were negligible decreases in most of the Region and increases in Libya and Syria.
- The Region is off-track: the rate of mortality reduction is too slow to achieve the SDG target of reducing premature mortality from major NCDs by one third by 2030 (from 25% in 2015 to 17% by 2030).

**Key message**

- NCDs account for more than 66% of all deaths in 2019 in the Region and cause on average one in four premature adult deaths, therefore addressing the regional NCD epidemic is a priority requiring a multisectoral approach to implement evidence-based, cost-effective public health interventions for the prevention and control of NCDs known as “WHO best buys”.

**3.4.1 Probability of dying from any cardiovascular disease, cancer, diabetes, chronic respiratory diseases between age 30 and exact age 70, 2010–2019**



## Challenges

- Political instability and conflict in 50% of countries of the Region and the impact of COVID-19 with its risks to economic and financial stability are negatively impacting development and health, affecting both access to services as well as NCD surveillance.
- Lack of multisectoral, multistakeholder national NCD responses and coordination mechanisms, weak governance and poor public sector regulatory capacity, coupled with a predominant private sector, especially in low- and middle-income countries.
- Lack of comprehensive national NCD monitoring frameworks to ensure policy coherence, the fragmentation of data and reporting systems, and the limited capacity of national health information systems to report and integrate data on NCD morbidity, mortality and risk factors, and to monitor progress towards SDG targets.
- Lack of financing and investment in addressing NCDs as entry point to achieve UHC and SDG-related targets.

## Steps for accelerated action

- Integrate NCDs into UHC Benefit Packages through a primary health care approach.
- Integrate NCDs into humanitarian preparedness, response and recovery plans.
- Implement the WHO technical packages to address NCDs and related risk factors such as HEARTS PEN, mPOWER, REPLACE, SHAKE and ACTIVE.
- Implement the Regional Cervical Cancer Elimination Strategy for the Eastern Mediterranean including introducing hepatitis and human papillomavirus vaccination, early detection, screening and treatment of cervical and other preventable or treatable cancers.
- Invest in NCD data systems that allow for the collection and reporting of disaggregated data, including strengthening of mortality registration by cause of death and linkage of mortality records to disease registries (especially cancer registries as a core element).
- Integrate NCD data systems into existing health information systems, especially at the level of primary care.

## Available guidance/tools

- Global action plan for the prevention and control of NCDs 2013–2020 (extended to 2030 by Decision WHA72(11) 2019 (<https://www.who.int/publications/i/item/9789241506236>))
- Tackling NCDs: ‘best buys’ and other recommended interventions for the prevention and control of noncommunicable diseases. WHO; 2017 (<https://apps.who.int/iris/handle/10665/259232>)
- Regional framework of action on NCDs (<https://www.emro.who.int/noncommunicable-diseases/framework-for-action/index.html>) and other regional frameworks addressing specific NCDs (<https://www.emro.who.int/noncommunicable-diseases/diseases/diseases.html>)

## WHO NCD packages:

- HEARTS: Technical package for cardiovascular disease management in primary health care: Risk-based CVD management (<https://www.who.int/publications/i/item/hearts-technical-package>)
- Package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings (<https://www.who.int/publications/i/item/9789240009226>)
- MPOWER measures (<https://www.who.int/initiatives/mpower>)
- SHAKE the salt habit (<https://www.who.int/publications/i/item/WHO-NMH-PND-16.4>)
- REPLACE, trans fat-free by 2023 (<https://www.who.int/teams/nutrition-and-food-safety/replace-trans-fat>)
- ACTIVE: a technical package for increasing physical activity (<https://www.who.int/publications/i/item/9789241514804>)
- Eastern Mediterranean Region publications on NCDs (<http://www.emro.who.int/noncommunicable-diseases/publications/>)
- WHO Global Diabetes Compact (<https://www.who.int/initiatives/the-who-global-diabetes-compact/>)
- WHO Global Initiative for Childhood Cancer – which aims to achieve at least a 60% survival rate for children with cancer by 2030 (<https://www.who.int/publications/m/item/who-global-initiative-for-childhood-cancer-an-overview>)
- Global strategy to accelerate the elimination of cervical cancer as a public health problem (<https://www.who.int/publications/i/item/9789240014107>)

### Key references

- EB152/6 - Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and mental health - Draft updated menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases. Geneva: World Health Organization; 2023 ([https://apps.who.int/gb/ebwha/pdf\\_files/EB152/B152\\_6-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/EB152/B152_6-en.pdf))
- Noncommunicable diseases progress monitor 2020. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/i/item/9789240000490>)

- Noncommunicable diseases country profiles 2018. Geneva: World Health Organization; 2018 (<https://www.who.int/publications/i/item/9789241514620>)

### Data sources

- WHO Global Health Observatory. Probability of dying between the exact ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases (SDG 3.4.1) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/probability-of-dying-between-exact-ages-30-and-70-from-any-of-cardiovascular-disease-cancer-diabetes-or-chronic-respiratory-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/probability-of-dying-between-exact-ages-30-and-70-from-any-of-cardiovascular-disease-cancer-diabetes-or-chronic-respiratory-(-)))
- WHO NCD data portal (<https://ncdportal.org/>)

**Indicator 3.4.2: Suicide mortality rate**

**Current situation**

- The median of the suicide mortality rate in the Region decreased modestly from 5.6 deaths per 100 000 population in 2010 to 4.9 deaths per 100 000 population in 2019.
- Of all countries in the Region in 2019, suicide mortality rate was lowest in Jordan (1.6 deaths per 100 000 population) and highest in Djibouti (9.6 deaths per 100 000 population).
- Between 2010 and 2019, the suicide mortality rate in the Region declined in 13 countries but increased in nine countries; three (Djibouti, Pakistan and Bahrain) have a burden of nearly 9 deaths per 100 000 population or higher.
- Estimates of suicide mortality rate were not available for any year for occupied Palestinian territory.

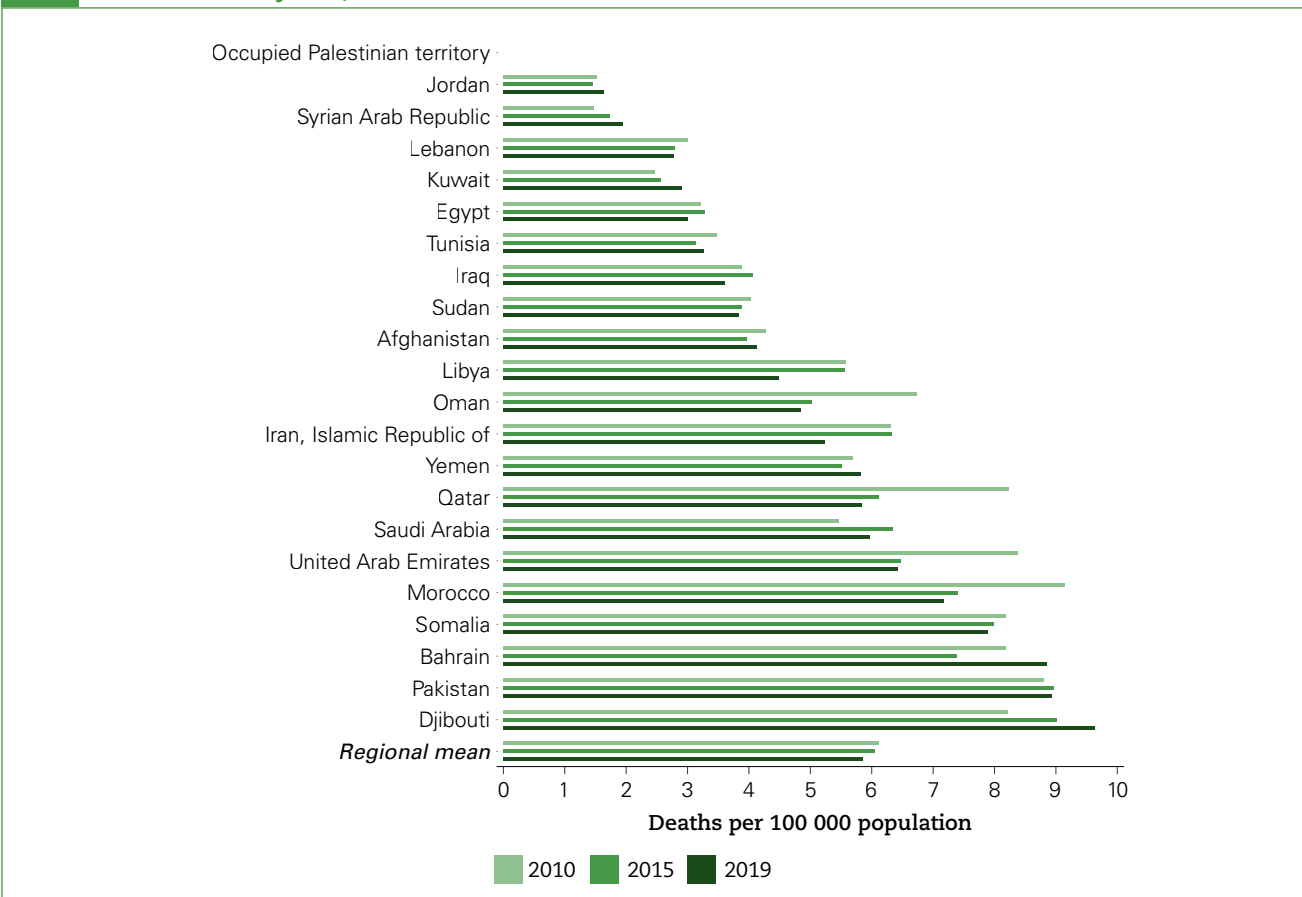
**Key message**

- Develop and implement comprehensive multisectoral suicide prevention strategies that include evidence-based interventions for preventing suicides and suicide attempts in relevant sectors, address stigma and support those bereaved by suicide.

**Challenges**

- Lack of evidence-based intersectoral policy support as only one third of countries globally (32.5%) have adopted a comprehensive national strategy or action plan, and regionally this proportion is even lower.
- Only one country in the Region has good vital registration of suicide mortality compared to 60 countries globally; in other countries, estimated suicide rates are based on modelling.

**3.4.2 Suicide mortality rate, 2010–2019**



- In most countries of the Region, suicide is not perceived to be a significant public health concern due to sociocultural and religious taboos leading to stigma associated with suicide; in some countries, suicidal behaviour is still criminalized.
- Suicide prevention and management of suicidal behaviours are not part of the UHC package in the majority of countries and are not part of the teaching/training curricula for health-care staff and first responders.

### Steps for accelerated action

- Develop comprehensive multisectoral national suicide prevention strategies for an effective national response.
- Establish/strengthen surveillance and quality data collection for suicide and suicide attempts, including in civil registration and vital statistics systems.
- Include evidence-based interventions for preventing suicides and suicide attempts as part of the UHC service package, such as reducing access to means, responsible media reporting, school-based life skills interventions, early identification and treatment of mental and substance use disorders, follow-up care, community support and crisis help lines.
- Conduct targeted campaigns to fight stigma and support those bereaved by suicide.

### Available guidance/tools

- Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm (<https://www.who.int/publications/i/item/practice-manual-for-establishing-and-maintaining-surveillance-systems-for-suicide-attempts-and-self-harm>)
- Preventing suicide: a resource series (<https://www.who.int/publications/i/item/preventing-suicide-a-resource-series>)

- Public health action for the prevention of suicide. A framework (<https://www.who.int/publications/i/item/9789241503570>)
- Suicide prevention: toolkit for engaging communities (<https://www.who.int/publications/i/item/suicide-prevention-toolkit-for-engaging-communities>)
- Preventing suicide: a manual for case registration of suicide and attempted suicide (<https://apps.who.int/iris/handle/10665/250536>)
- WHO Mental Health Gap Action Programme (mhGAP) [website] (<https://www.who.int/publications/i/item/9789241596206>)
- LIVE LIFE: Preventing suicide [brochure and flyer] (<https://www.who.int/publications/i/item/live-life-preventing-suicide>)

### Key references

- Suicide in the world: global health estimates. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/326948>)
- National suicide prevention strategies: progress, examples and indicators. Geneva: World Health Organization; 2018 (<https://www.who.int/publications/i/item/national-suicide-prevention-strategies-progress-examples-and-indicators>)
- Preventing suicide: a global imperative. Geneva: World Health Organization; 2014 (<https://www.who.int/publications/i/item/9789241564779>)

### Data sources

- WHO Global Health Observatory. Suicide mortality rate (per 100 000 population) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/suicide-mortality-rate-\(per-100-000-population\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/suicide-mortality-rate-(per-100-000-population)))

Goal  
3

**Target 3.5:** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

■ **Indicator 3.5.2: Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol**

**Current situation**

- The median total alcohol per capita (APC) consumption among individuals aged 15 years and older in the Region declined from 0.4 litres in 2010 to 0.31 litres in 2019 in line with the global APC decline from 5.7 litres in 2010 to 5.5 litres in 2019. Alcohol consumption per capita was the lowest among all WHO regions.
- In all countries of the Region, total alcohol per capita consumption remained below 2.5 litres of pure alcohol over the period 2010–2019 except

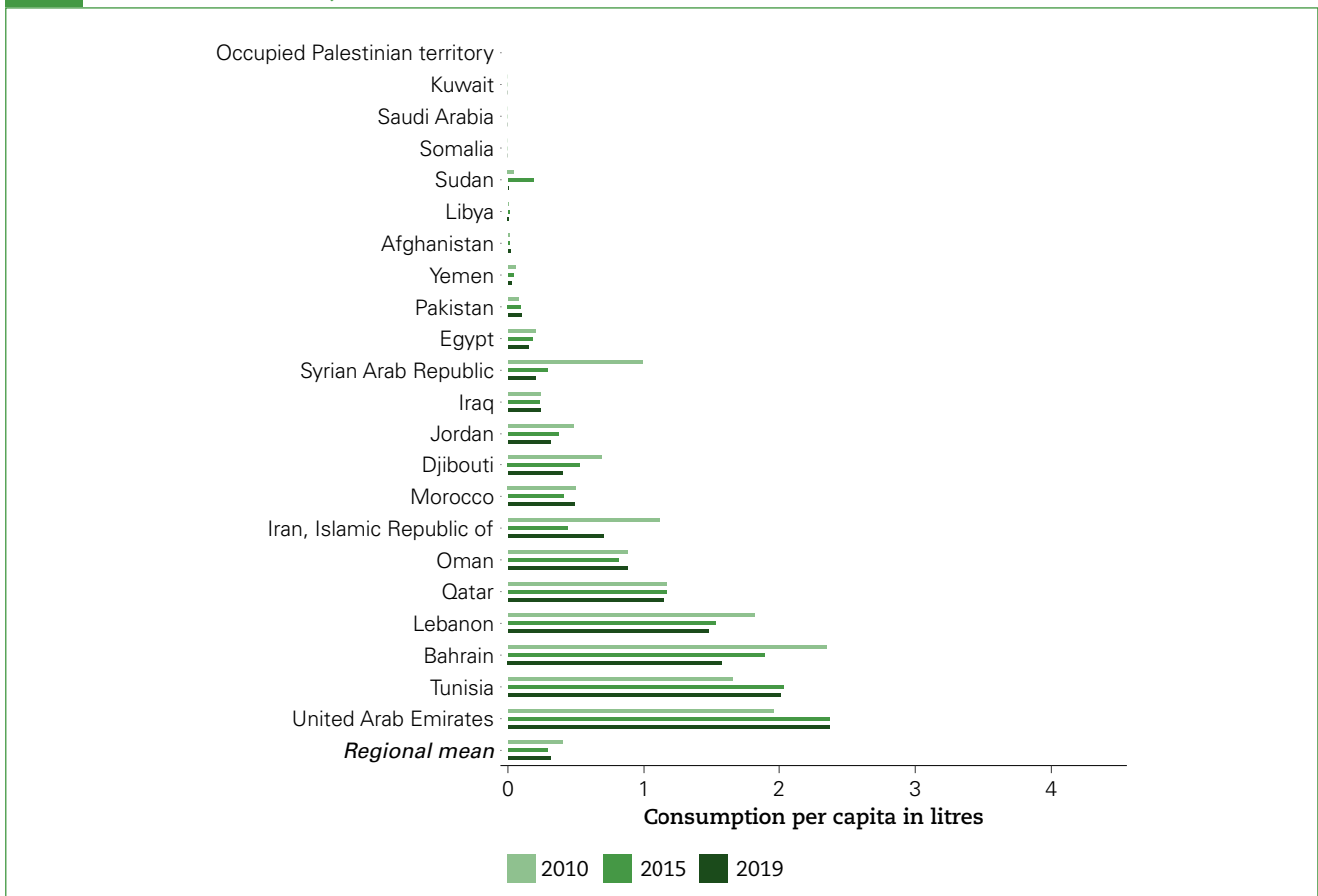
for men in Tunisia, the United Arab Emirates and Lebanon.

- Alcohol per capita consumption in all countries of the Region was consistently higher in men than women.
- In 2019, total alcohol per capita consumption in the Region ranged from zero in Kuwait, Saudi Arabia and Somalia to 2.37 litres in the United Arab Emirates.
- Alcohol per capita consumption by sex was highest in Tunisia at 3.61 litres for men and 0.49 litres for women.
- Alcohol per capita consumption showed a consistent decline across the countries of the Region between 2010 and 2019, except in three countries (Pakistan, Tunisia and United Arab Emirates).

**Key message**

- Implement high-impact evidence-based strategies, policies and interventions from the Global Alcohol Action Plan 2022–2030 to reduce the harmful use of alcohol, adapted to the country context.

**3.5.2 Harmful alcohol use, 2010–2019**





### Challenges

- In the Region, unrecorded drinking accounts for a high proportion (70.5%) of total alcohol consumption.
- High levels of alcohol consumption among drinkers in the Region are leading to harmful health consequences. For example, alcohol consumption has had a net detrimental age-standardized effect on diabetes in the Region, causing 0.1 deaths and 4.0 DALYs per 100 000 people.
- Lack of a national alcohol policy/strategy to reduce the harmful use of alcohol in most countries of the Region (82%).
- Very limited data available on alcohol consumption, its harmful consequences, treatment services for alcohol use disorders and the treatment coverage for alcohol use disorders in the Region.

### Steps for accelerated action

- Develop and strengthen evidence-based national alcohol policies that consider the social, cultural and religious contexts. Even in countries with a

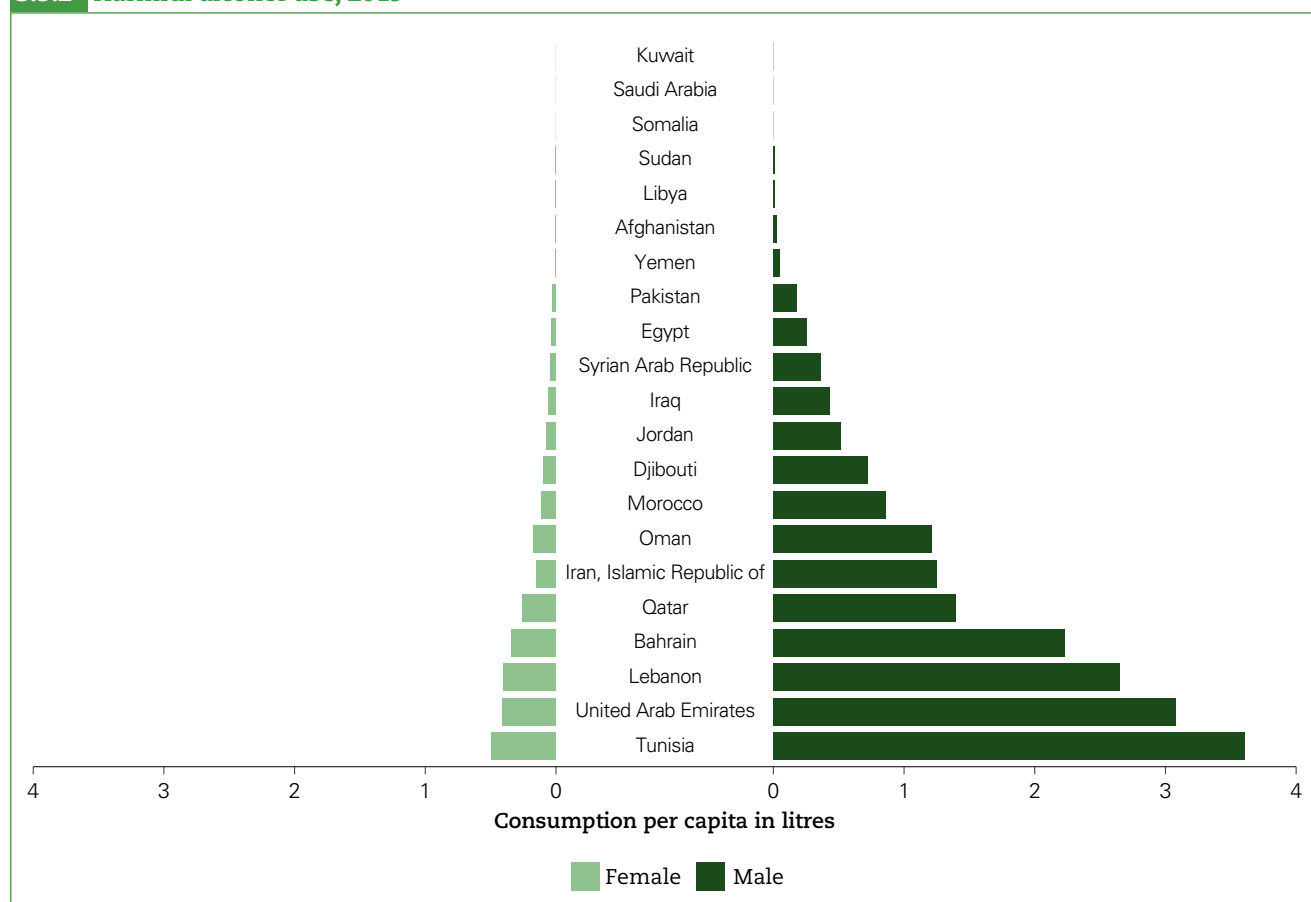
total ban on alcohol, a national policy on alcohol use allows the country to monitor and address the public health consequences of alcohol use.

- Establish an effective monitoring and surveillance system to collect information on alcohol consumption and its harmful consequences using definitions and data-collection procedures compatible with WHO's global and regional information systems.
- Build and enhance the capacity of the health-care system to provide prevention, treatment and care services for alcohol use disorders and coexisting conditions.

### Available guidance/tools

- The SAFER technical package: five areas of intervention at national and subnational levels. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/330053>)
- Global Information System on Alcohol and Health (GISAH) [online database] (<https://www.who.int/data/gho/data/themes/global-information-system-on-alcohol-and-health>)

### 3.5.2 Harmful alcohol use, 2019





### Goal 3

- Resource tool on alcohol taxation and pricing policies. Geneva: World Health Organization; 2017 (<https://www.who.int/publications/item/9789241512701>)

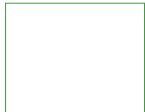
#### Key references

- Global Alcohol Action Plan 2022–2030 to effectively implement the Global strategy to reduce the harmful use of alcohol as a public health priority. Geneva: World Health Organization; 2022 (<https://www.who.int/teams/mental-health-and-substance-use/alcohol-drugs-and-addictive-behaviours/alcohol/our-activities/towards-and-action-plan-on-alcohol>)
- Global status report on alcohol and health 2018. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1>)

- Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization; 2010 (<https://www.who.int/teams/mental-health-and-substance-use/alcohol-drugs-and-addictive-behaviours/alcohol/governance/global-alcohol-strategy>)

#### Data sources

- WHO Global Health Observatory. SDG Target 3.5 Substance abuse ([https://www.who.int/data/gho/data/themes/topics/sdg-target-3\\_5-substance-abuse](https://www.who.int/data/gho/data/themes/topics/sdg-target-3_5-substance-abuse))



**Target 3.6:** By 2030, halve the number of global deaths and injuries from road traffic accidents

**Indicator 3.6.1: Death rate due to road traffic injuries**

**Current situation**

- Target 3.6 aims to halve the number of global deaths and injuries from road traffic accidents by 2030.
- The estimated mortality rate from road traffic injuries in the Region declined from 20 deaths per 100 000 population in 2010 to 18 deaths per 100 000 population in 2015 and remained at that level in 2019.
- Between 2010 and 2019, the mortality rate from road traffic injuries in the Region declined in 15 countries but increased in five countries (Afghanistan, Lebanon, Sudan, Yemen, and

Iraq). Estimates of the mortality rate from road traffic injuries were not available for any year for occupied Palestinian territory.

- Between 2010 and 2019, the mortality rate from road traffic injuries declined by at least 50% in Oman, Qatar, United Arab Emirates and Bahrain, thus achieving the SDG target.
- Between 2010 and 2019, the mortality rate from road traffic injuries increased by 25% or more in Yemen and Iraq.

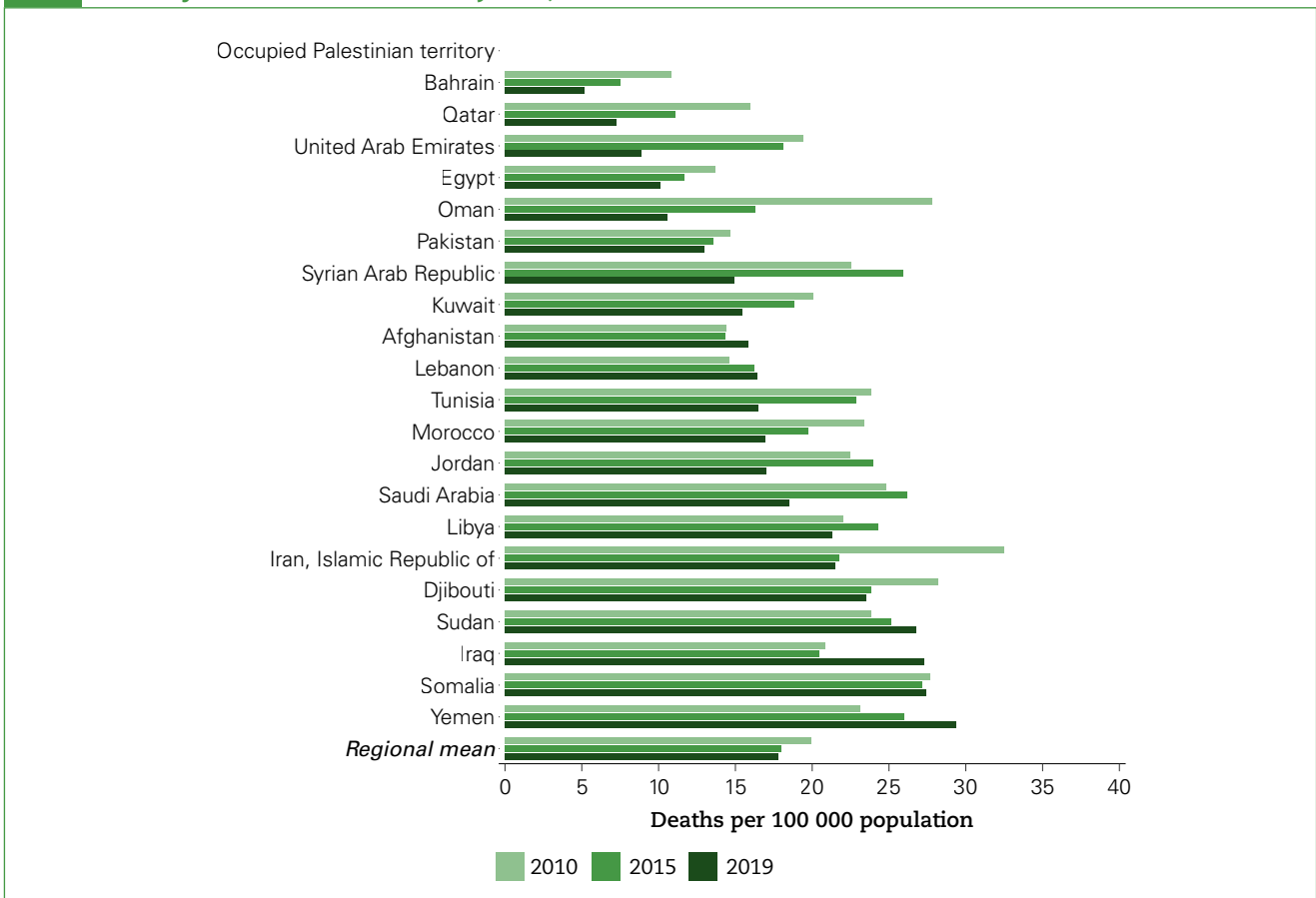
**Key message**

- The strong momentum created by the Decade of Action for Road Safety 2021–2030 with commitment at all levels, together with innovations and advances in different areas of road safety, and the availability of proven evidence-based interventions and guidance, provide a unique opportunity to build on progress in reducing road traffic deaths and injuries.

**Challenges**

- Insufficient adoption of a holistic safe system approach including for post-crash emergency care.

**3.6.1 Mortality rate from road traffic injuries, 2010–2019**



- Multiplicity and fragmentation of data sources with underreporting and lack of standard definition of deaths and injuries.
- Weak regulatory environment, including:
  - a. national laws that do not meet best practice on all of the five key road safety behavioural risk factors;
  - b. failure to meet international standards for vehicles and road infrastructure; and
  - c. inadequate enforcement, implementation and evaluation of policy and legislative frameworks.
- Insufficient consideration of the needs of all road users, including vulnerable road users (such as pedestrians, motorcyclists and cyclists).
- Contextual challenges including crisis and post-crisis situations.

### Steps for accelerated action

- Review/update national plans for road safety based on the new global plan for the second Decade of Action for Road Safety 2021–2030 in line with the specific national context.
- Evaluate country-level implementation of road safety interventions, their cost-effectiveness and impact on reducing road traffic deaths and injuries.
- Improve both the consistency and quality of road traffic data by adopting a standard definition of road traffic death and injuries and improving data linkages between multiple sectors and data sources.
- Update/enact laws and regulations that meet best practice criteria on behavioural risk factors and strictly enforce them, including implementing the United Nations vehicle safety regulations or equivalent national standards and best practice road standards to improve the safety of all road users.

- Develop/improve organized and integrated pre-hospital and facility-based emergency care systems.

### Available guidance/tools

- Global Plan for the Decade of Action for Road Safety 2021–2030 (<https://www.who.int/publications/m/item/global-plan-for-the-decade-of-action-for-road-safety-2021-2030>)
- Documenting road safety: A guide for governments and lead agencies (<https://apps.who.int/iris/handle/10665/365877>)
- Global status report on road safety 2018 (<https://www.who.int/publications/i/item/9789241565684>)
- Save lives: a road safety technical package (<https://www.who.int/publications/i/item/save-lives-a-road-safety-technical-package>)
- Data systems: a road safety manual for decision-makers and practitioners (<https://apps.who.int/iris/handle/10665/44256>)
- Strengthening road safety legislation: a practice and resource manual for countries (<https://www.who.int/publications-detail-redirect/strengthening-road-safety-legislation>)
- Decade of Action for Road Safety 2021–2030 [website] (<https://www.who.int/teams/social-determinants-of-health/safety-and-mobility/decade-of-action-for-road-safety-2021-2030>)

### Data sources

- WHO Global Health Observatory. Estimated road traffic death rate (per 100 000 population) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-road-traffic-death-rate-\(per-100-000-population\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-road-traffic-death-rate-(per-100-000-population)))

**Target 3.7:** By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

**Indicator 3.7.1:** Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods

### Current situation

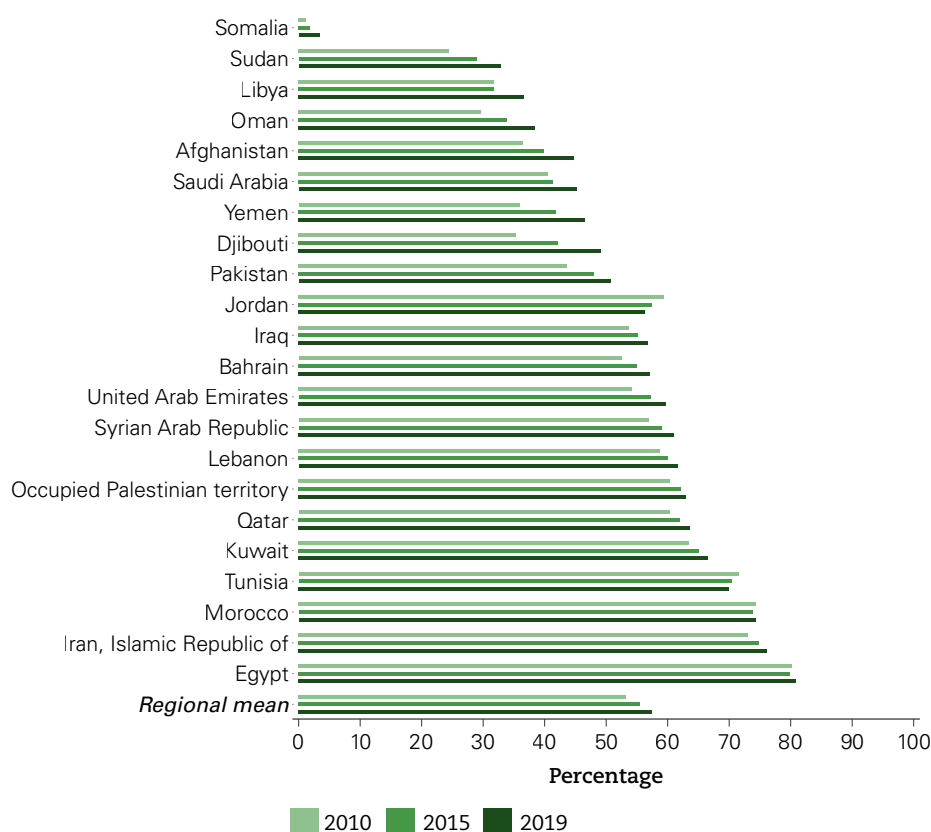
- In most countries in the Region, the increase in the proportion of women of reproductive age who had their need for family planning satisfied with modern methods was small over the period 2015–2020.

- The proportion of women of reproductive age having their need for family planning satisfied with modern methods remained lowest in Somalia (from 1.2% in 2010 to 3.4% in 2020) and highest in Egypt (from 80.2% in 2010 to 80.9% in 2020).
- By 2020, two thirds of women of reproductive age had their need for family planning satisfied with modern methods in six countries, one more country than in 2010.
- In 2020, less than half (50%) of women of reproductive age had their need for family planning satisfied with modern methods in Somalia, Sudan, Libya, Oman, Afghanistan, Saudi Arabia, Yemen and Djibouti.

### Key message

- Integrate WHO updated family planning guidelines into national policies and strategies including increasing funding for appropriate method mix and ensuring trained workforce in order to provide high quality family planning services addressing the needs of women and couples.

**3.7.1 Women of reproductive age (15–49) who had their need for family planning satisfied with modern methods, 2010–2020**



## Challenges

- There are limited national policies, regulations and strategies promoting family planning in response to women's and couples' needs. Further, there are national policies opposed to family planning services in some countries.
- Limited family planning method mix and choice of method, shortages of modern family planning methods and associated commodities (syringes for example), inequitable access to family planning services and limited contraception care coverage.
- Limited quality of care, with poor family planning counselling for women and couples leading to fear of side-effects.
- Sociocultural and gender-based barriers due to misconceptions and misguided attitudes towards the adoption of modern family planning methods.

## Steps for accelerated action

- Adopt and adapt the updated WHO family planning guidelines and recommendations within national policies, strategies, plans and guidelines in response to the needs of women and couples.
- Secure domestic family planning funding and a modern method mix, including new methods at health facility level.
- Address family planning workforce shortages, assure equitable distribution and reinforce health professional training on the updated WHO family planning recommendations via pre- and in-service training.
- Improve the quality of care in contraception services through good counselling and communication.
- Ensure the integration of family planning services within the sexual and reproductive health continuum of care.
- Inform and raise the awareness of women and couples about the benefits of family planning and the prevention and management of side-effects.

## Available guidance/tools

- Family planning – a global handbook for providers. 2022 edition (<https://fphandbook.org/sites/default/files/WHO-JHU-FPHandbook-2022Ed-v221114b.pdf>)
- Medical eligibility criteria for contraceptive use. Fifth edition. 2015 (<https://www.who.int/publications/i/item/9789241549158>)
- A guide to identifying and documenting best practices in family planning programmes. 2017 (<https://www.who.int/publications/i/item/a-guide-to-identifying-and-documenting-best-practices-in-family-planning-programmes>)
- WHO concise guide to implementing and scaling up family planning service improvements. 2018 (<https://fps-scale-up-guide.srhr.org/>)
- Implementation guide for the medical eligibility criteria and selected practice recommendations for contraceptive use guidelines. 2018 (<https://www.who.int/publications/i/item/9789241513579>)

## Key references

- Health topic: Contraception (<https://www.who.int/health-topics/contraception>)
- Task sharing to improve access to family planning/contraception. Summary brief. Geneva: World Health Organization; 2018 (<https://www.who.int/publications/i/item/WHO-RHR-17.20>)
- Training resource package for family planning (<https://www.fptraining.org/>)
- Fact sheet: Emergency contraception (<https://www.who.int/news-room/fact-sheets/detail/emergency-contraception>)
- Q&A: Coronavirus disease (COVID-19): Contraception and family planning (<https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-contraception-and-family-planning>)

## Data sources

- United Nations Population Division Data Portal (<https://population.un.org/dataportal/home>)

**Indicator 3.7.2: Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group**

- Adolescent pregnancies expose the mother and the baby to enhanced risks. Adolescent mothers (aged 10–19 years) face higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birth weight, preterm birth and severe neonatal condition.

**Current situation**

- There were small changes in adolescent fertility in most countries of the Region between 2015 and 2021.
- The adolescent birth rate in the Region decreased from 54 births per 1000 women aged 15–19 years in 2015 to 47 births per 1000 women aged 15–19 years in 2021.

- There were large variations in adolescent birth rates in the Region during the same period.
- In 2018, the adolescent birth rate in the Region ranged from 5 births per 1000 women aged 15–19 years in the United Arab Emirates to 54 births per 1000 women aged 15–19 years in Pakistan.

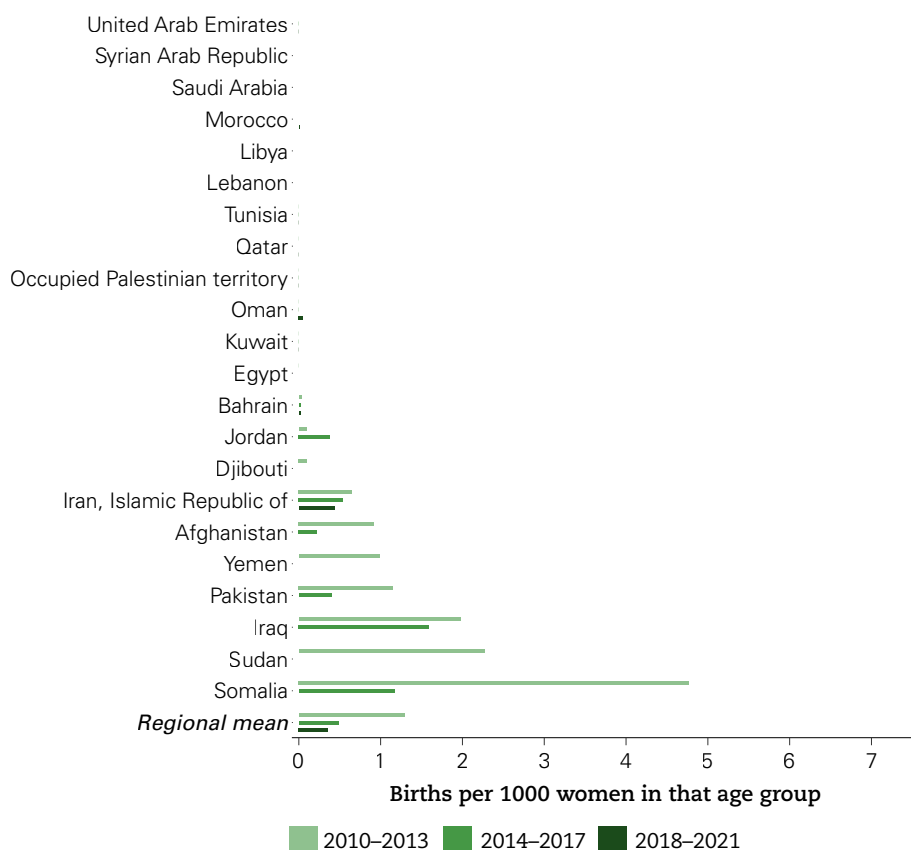
**Key message**

- Implement a multisectoral approach to the provision of high-quality adolescent health-care services using a life-course approach in line with the Global accelerated action for the health of adolescents (AA-HA!) guidance.

**Challenges**

- Addressing adolescent fertility issues has strong sociocultural aspects, including low mean age of marriage as well as the presence of childhood marriage in most communities of the Region.
- Lack of prioritization of adolescent health on the national health agenda.
- Political instability and emergencies, particularly in conflict-affected settings.

**3.7.2 Adolescent birth rate (aged 10–14 years) per 1000 women, 2010–2021**



**Goal  
3**

- Insufficient information on adolescent fertility, including disaggregated data by age, sex and other stratifiers.
- Poor access to, and integration of, adolescent health services including reproductive health services in primary health-care settings.

**Steps for accelerated action**

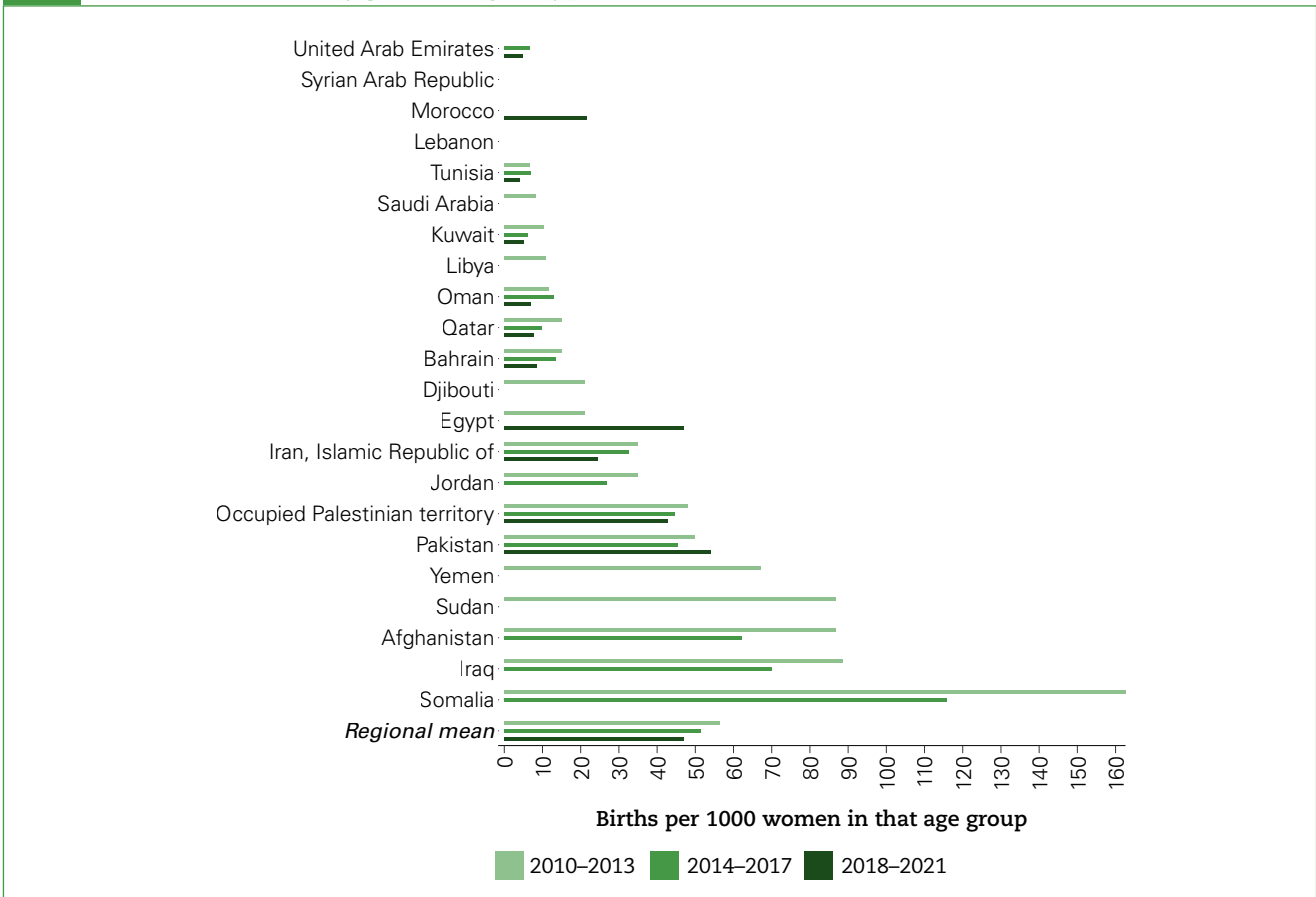
- Implement resolution EM/RC64/R.4 on “Operationalization of the adolescent health component of the Global Strategy for Women’s, Children’s and Adolescents’ Health, 2016–2030” by adopting the Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation.
- Advocate adolescent sexual and reproductive health issues to policy-makers with strong community engagement.
- Engage adolescents in different stages of planning, implementation, and monitoring and evaluation of SRH programmes.

- Adopt a multisectoral approach to improve the reproductive health of adolescents through a life-course approach.
- Integrate adolescent health services into primary health care to improve access to quality, friendly and comprehensive health-care services.
- Build national capacity for the provision of quality adolescent health-care services.
- Prioritize adolescent health issues in humanitarian settings.
- Currently, WHO is updating the guidelines on preventing early marriages and early pregnancies.

**Available guidance/tools**

- Operationalization of the adolescent health component of the Global Strategy for Women’s, Children’s and Adolescents’ Health, 2016–2030. Regional Committee for the Eastern Mediterranean. Sixty-fourth session. Agenda item 3(C). EM/RC64/R.4. October 2017 ([https://applications.emro.who.int/docs/RC64\\_Resolutions\\_2017\\_R4\\_20133\\_EN.pdf](https://applications.emro.who.int/docs/RC64_Resolutions_2017_R4_20133_EN.pdf))

**3.7.2 Adolescent birth rate (aged 15–19 years) per 1000 women, 2010–2021**





- Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation. 2017 ([https://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/framework-accelerated-action/en/](https://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/))
- WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: World Health Organization; 2018 (<https://www.who.int/publications/i/item/9789241514606>)
- Regional implementation framework on ending preventable newborn, child and adolescent deaths and improving health and development 2019–2023. Regional Committee for the Eastern Mediterranean. Sixty-sixth session. Provisional agenda item 3(a) (<https://apps.who.int/iris/handle/10665/371139>)
- Child and adolescent health in humanitarian settings operational guide: a holistic approach for programme managers. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (<http://www.emro.who.int/child-adolescent-health/information-resources/index.html>)
- Global strategy for women’s, children’s and adolescents’ health data portal. Survive–Thrive–Transform (<https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data>)
- Guideline: implementing effective actions for improving adolescent nutrition. Geneva: World Health Organization; 2018 (<https://www.who.int/publications/i/item/9789241513708>)
- Assessing and supporting adolescents’ capacity for autonomous decision-making in health-care settings: a tool for health-care providers. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240039568>)

#### Data sources

- WHO Global Health Observatory. Adolescent birth rate (per 1000 women) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adolescent-birth-rate-\(per-1000-women-aged-15-19-years\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adolescent-birth-rate-(per-1000-women-aged-15-19-years)))

Goal  
3

**Target 3.8:** Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

■ **Indicator 3.8.1: Coverage of essential health services**

**Current situation**

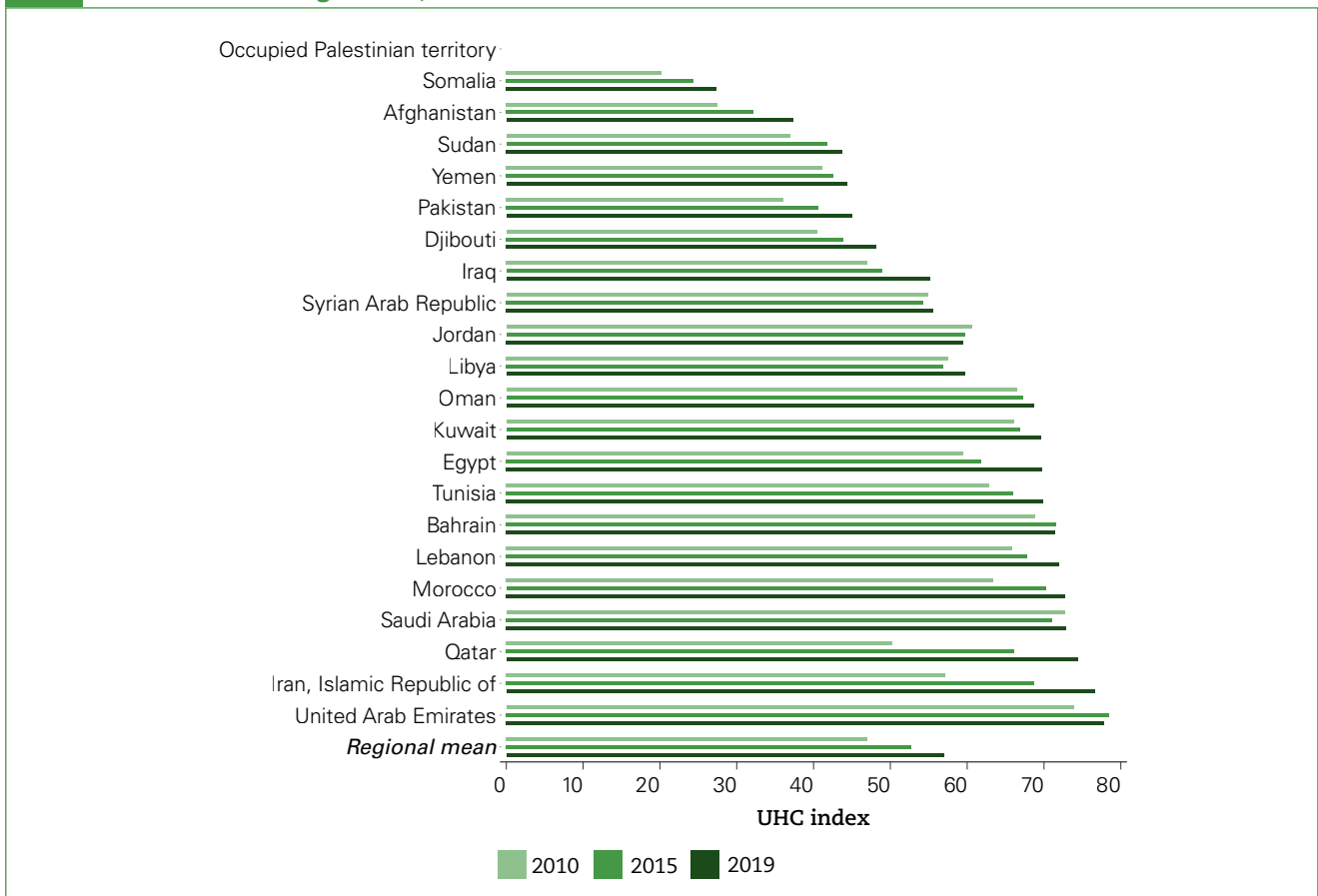
- There were modest improvements in the UHC service coverage index in most countries of the Region between 2010 and 2019: the median UHC service coverage index in the Region increased by more than 10 points, from 57.6 in 2010 to 68.7 in 2019.
- The UHC service coverage index increased by 10 or more points in Egypt, Islamic Republic of Iran and Qatar between 2010 and 2019.

- Jordan was the only country in the Region to experience a reversal in the UHC service coverage index between 2010 and 2019. The influx of refugees from Iraq, Yemen, Sudan and Somalia, 83% of whom are not living in refugee camps where essential services have been maintained, may be a key reason for this trend.
- On a unit scale of 0 to 100, the UHC service coverage index in the Region in 2019 ranged from 27.3 in Somalia to 77.8 in the United Arab Emirates.
- In 2019, the UHC service coverage index was greater than 50 in all countries of the Region except Somalia, Afghanistan, Sudan, Yemen, Pakistan and Djibouti.

**Key message**

- Develop and implement an evidence-informed UHC package of services based on high-quality, primary health-care oriented models of care to reach SDG target 3.8, the UHC2030 target (UHC by 2030).

**3.8.1 UHC service coverage index, 2010–2019**



## Challenges

- Increased numbers of refugees and displaced populations in the Region.
- Lack of data on the patient and community perspective on health services coverage.
- Data gaps on service coverage limit the ability of countries to monitor progress on the ground, including disaggregated data (for example, by geography, sex, age, race/ethnicity and migratory status) and subnational data.
- Low levels of funding and unbalanced allocations to urban curative services over preventive services and primary care.
- Fragmentation of health services across public sector entities, and between levels of care and multiple types of providers (including between public and private sectors), hampers the integration and delivery of standardized service delivery packages.

## Steps for accelerated action

- Despite modest improvements in the coverage of essential health services in most of the countries, population growth rates will offset the gains being made; hence, to reach the target of UHC by 2030, coverage needs to be significantly increased.
- Expand health services using comprehensive and integrated packages, including preventive, promotive, curative, rehabilitative and palliative services, across all levels of care using a range of public and private sector providers and a functioning referral system.
- Enhance quality of care through institutionalized systems of patient safety, audit and surveillance.
- Health systems strengthening with a focus on equity is needed so that more people are provided with needed services over the life-course.
- Strengthen health information systems to enable the collection, analysis and use of disaggregated data to monitor key components of UHC (health systems, infectious disease, NCDs, and reproductive, maternal, newborn and child health).

- In emergency settings, broaden the use of the Humanitarian–Development–Peace nexus approach for building resilient health systems rather than focusing only on developing essential service packages and maintaining essential services.

## Available guidance/tools

- Universal health coverage (UHC) – priority benefits package. WHO Regional Office for the Eastern Mediterranean (<http://www.emro.who.int/uhc-ppp/index.html>)
- PHC oriented models of care. WHO Regional Office for the Eastern Mediterranean (<https://www.emro.who.int/uhc-health-systems/access-health-services/phc-oriented-models-of-care.html>)

## Key references

- Primary health care on the road to universal health coverage. 2019 Global monitoring report. Conference edition. Geneva: World Health Organization (<https://www.who.int/publications/item/9789240004276>)
- Tracking universal health coverage: 2021 Global monitoring report. WHO and the World Bank; 2022 (<https://www.who.int/publications/item/9789240040618>)
- Hogan DR, Stevens GA, Hosseinpoor AR, Boerma T. Monitoring universal health coverage within the Sustainable Development Goals: development and baseline data for an index of essential health services. *Lancet Glob Health*. 2018;6(2):e152–e168 ([https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30472-2/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30472-2/fulltext))

## Data sources

- WHO Global Health Observatory. UHC Service Coverage Index (SDG 3.8.1) (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage>)

**Indicator 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income (greater than 10% or 25%)**

**Current situation**

**Expenditure exceeding 10%**

- In 2019, only three countries (Saudi Arabia, United Arab Emirates and Islamic Republic of Iran) had estimates of the proportion of the population with household spending on health greater than 10% of total household expenditure or income. Among the three, the proportion of the population with household expenditures on health greater than 10% of total household expenditure or income was lowest in United Arab Emirates (0.4%) and highest in Islamic Republic of Iran (15.4%).
- Only Islamic Republic of Iran had estimates of the proportion of population with household expenditures on health greater than 10% of total household expenditure or income for 2010, 2015 and 2020.

**Expenditure exceeding 25%**

- In 2019, only two countries in the Region (Saudi Arabia and Islamic Republic of Iran) had estimates of the proportion of the population with household expenditures on health greater than 25% of total household expenditure or income: Saudi Arabia (0.6%) and Islamic Republic of Iran (3.5%).
- Only Islamic Republic of Iran had estimates of the proportion of population with household expenditures on health greater than 25% of total household expenditure or income for 2010, 2015 and 2020.

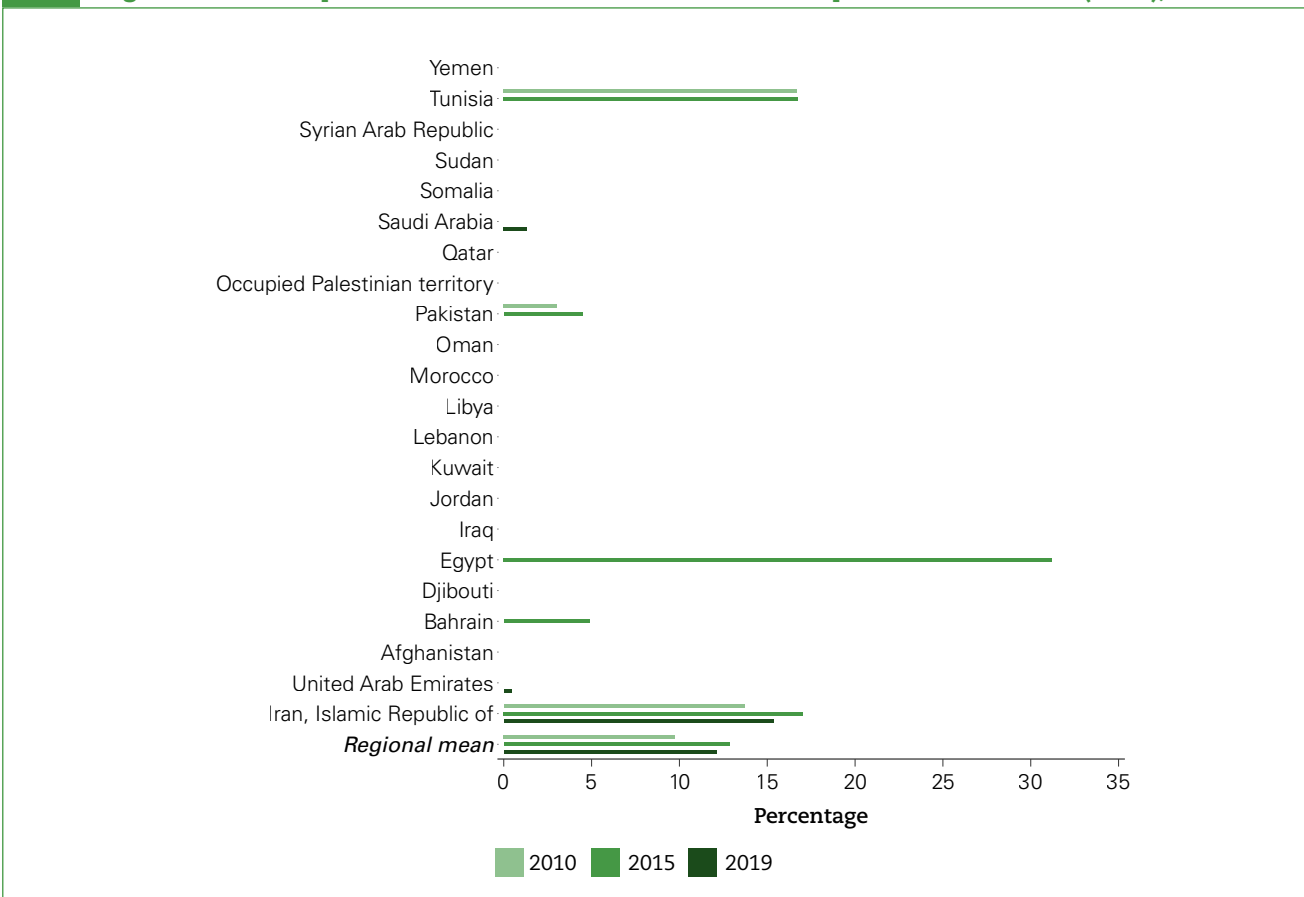
**Key message**

- Reform health financing and social protection based on available country-level evidence such as level of coverage by prepayment schemes, public spending on health and out-of-pocket spending on health.

**Challenges**

- Low public spending on health.

**3.8.2 Large household expenditure as a share of total health care expenditure or income (>10%), 2010–2019**



- High out-of-pocket costs are a major barrier to access and continuity of care and can push the poorest below or further below the poverty line.
- Fragmented health-care coverage with a growing unregulated private sector renders a large proportion of the population uninsured and uncovered.
- Most health systems are designed with a focus on efficiency at the expense of equity.

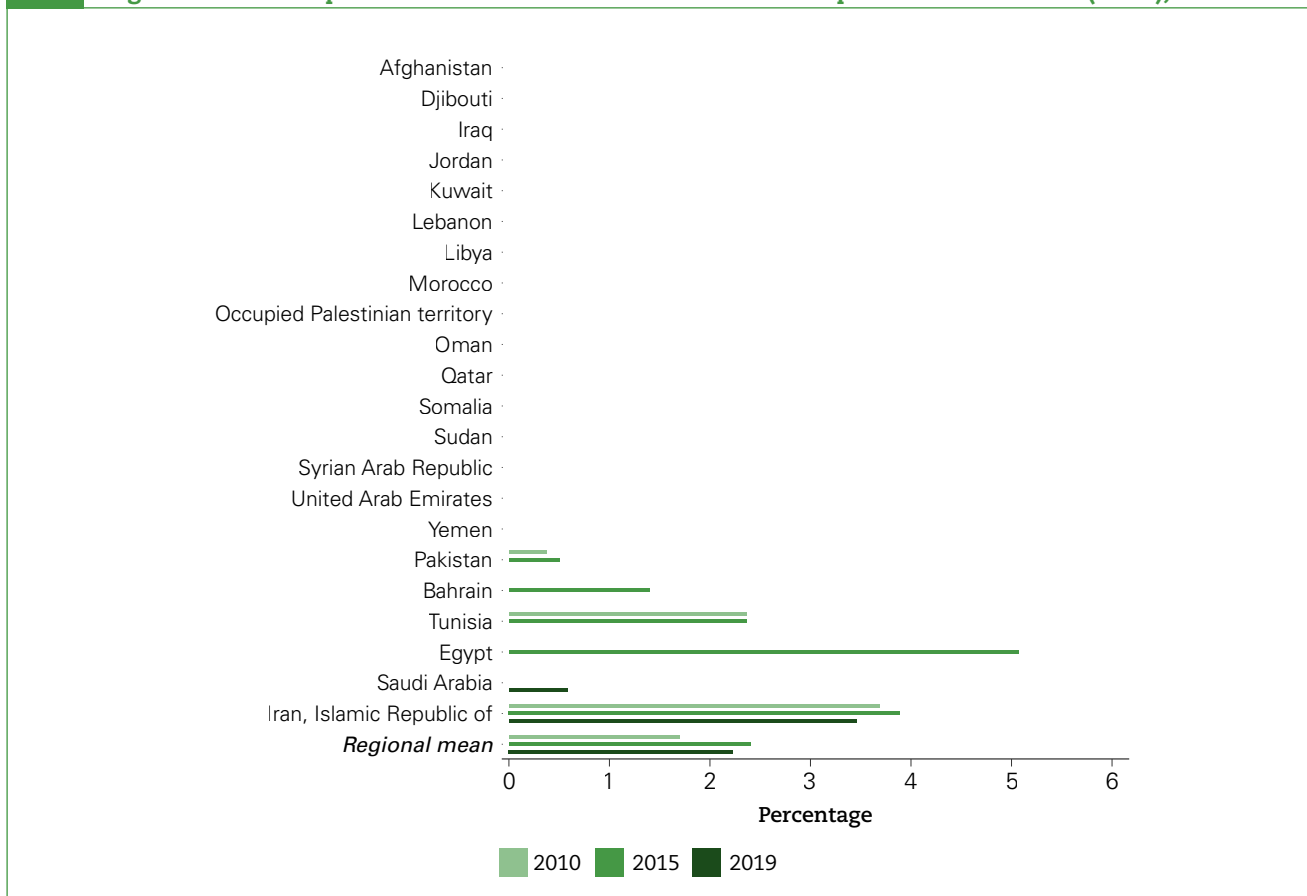
### Steps for accelerated action

- Ensure that additional resources are channelled through compulsory pre-paid pooled arrangements and not through out-of-pocket expenditures that expose households to financial risk.
- Improve cost-efficiency within the health sector through good governance for greater transparency

and accountability, institutionalizing analytical tools (such as national health accounts, burden of disease measurement, cost-effectiveness analysis and health technology assessment) and bulk purchasing of medicines, vaccines and health technologies.

- Mainstream equity in all health system strengthening endeavors on multiple fronts – within health and with sectors beyond health, at local, regional, national and international levels – led by and/or supported by the health sector.
- Produce and routinely analyse information on health expenditures (using System of Health Accounts 2011), financial protection and equity, and health financing policy implementation (e.g. using the health financing progress matrices) to guide priority-setting and resource allocation.

### 3.8.2 Large household expenditure as a share of total health care expenditure or income (>25%), 2010–2019



### Available guidance/tools

- Developing a national health financing strategy: a reference guide. Health Financing Guidance No 3. WHO; 2017 (<https://apps.who.int/iris/bitstream/10665/254757/1/9789241512107-eng.pdf>)
- Governance for strategic purchasing: an analytical framework to guide a country assessment. Health Financing Guidance No 6. WHO; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/330247/9789240000025-eng.pdf>)

### Key references

- Primary health care on the road to universal health coverage. 2019 Global monitoring report. Conference edition. Geneva: World Health Organization (<https://apps.who.int/iris/handle/10665/328913>)
- Towards universal health coverage: thinking public. Overview of trends in public expenditure on health (2000–2014). Health Financing Working Paper No 7. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/handle/10665/255782>)
- Tracking universal health coverage: 2017 Global monitoring report. WHO and the World Bank; 2017 (<https://apps.who.int/iris/handle/10665/259817>)

- Wagstaff A, Flores G, Hsu J, Smitz M-F, Chepynoga K, Buisman LR, et al. Progress on catastrophic health spending in 133 countries: a retrospective observational study. *Lancet Glob Health* 2018;6(2):e169–e179 (<https://pubmed.ncbi.nlm.nih.gov/29248367/>)

### Data sources

- WHO Global Health Observatory. Population with household expenditures on health greater than 10% of total household expenditure or income (SDG 3.8.2) (% , national, rural, urban) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-10-of-total-household-expenditure-or-income-\(sdg-3-8-2\)-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-10-of-total-household-expenditure-or-income-(sdg-3-8-2)-(-)))
- WHO Global Health Observatory. Population with household expenditures on health greater than 25% of total household expenditure or income (SDG indicator 3.8.2) (% , national, rural, urban) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-25-of-total-household-expenditure-or-income-\(sdg-indicator-3-8-2\)-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-25-of-total-household-expenditure-or-income-(sdg-indicator-3-8-2)-(-)))

**Target 3.9:** By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

**Indicator 3.9.1: Mortality rate attributed to household and ambient air pollution**

**Current situation**

- In 2019, the age-standardized mortality rate attributed to household and ambient air pollution in the Region ranged from 38.7 deaths per 100 000 population in Jordan to 265.7 deaths per 100 000 population in Afghanistan.
- Half of the countries in the Region in 2019 reported an age-standardized mortality rate attributed to household and ambient air pollution of greater than 90 deaths per 100 000 population.
- The age-standardized mortality rate attributed to household and ambient air pollution in Djibouti,

Yemen, Pakistan, Somalia and Afghanistan in 2019 exceeded 150 deaths per 100 000 population.

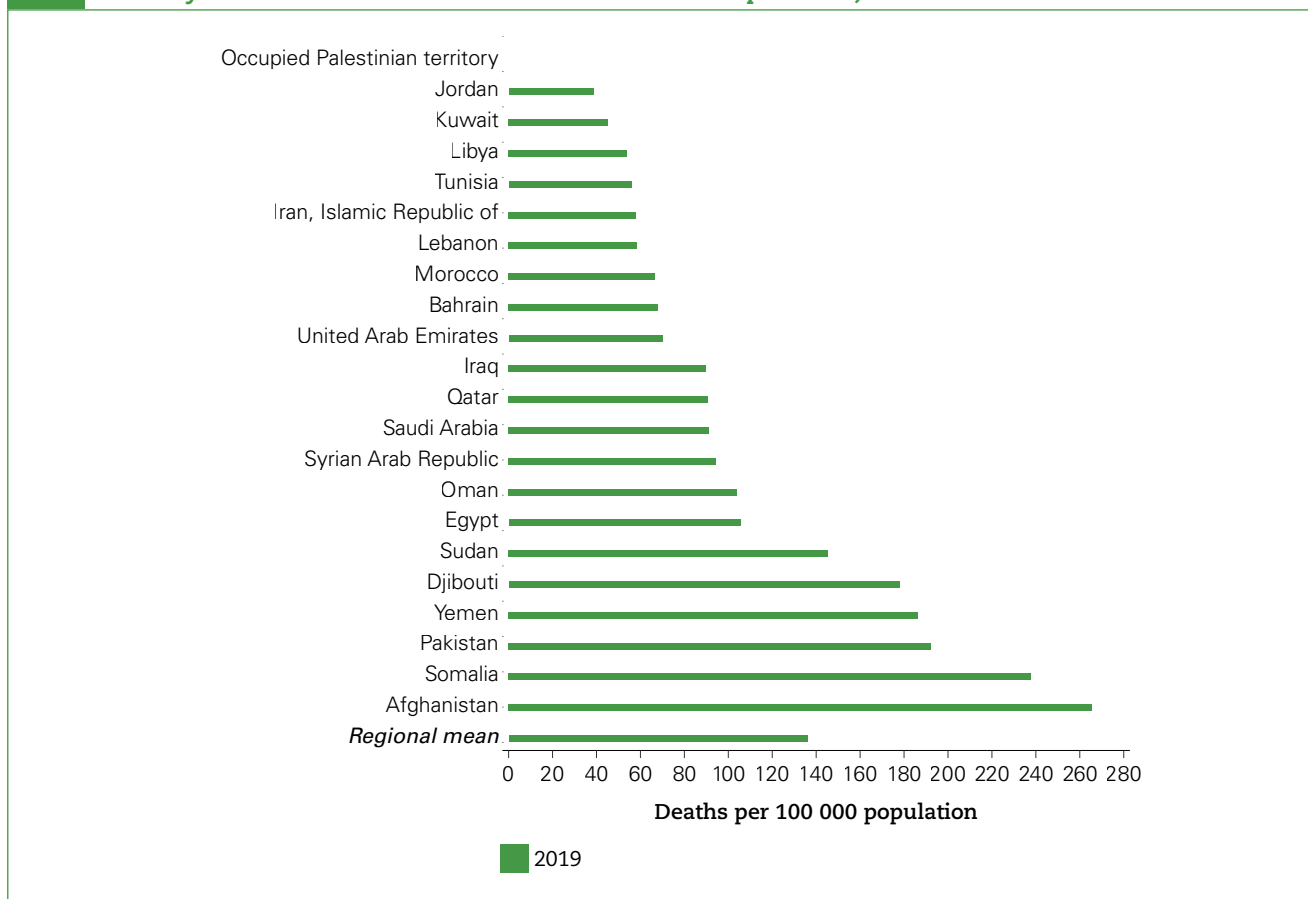
**Key message**

- Develop and implement comprehensive multisectoral strategies to address air pollution based on WHO air quality guidelines and building on Region/country-specific evidence.

**Challenges**

- Natural and anthropogenic sources of air pollution in the Region make the levels of air pollution with particulates the highest in the world. The existence of a toxic mixture of natural and anthropogenic particulate matter is a major challenge and there is limited understanding of its health impact.
- Weak environmental monitoring and health surveillance systems, including standards that do not align with international standards and limited region-specific evidence of the health impact of air pollution, along with a lack of related economic evaluation studies.

**3.9.1 Mortality rate attributed to household and ambient air pollution, 2010–2019**



- Poor coordination between all relevant stakeholders to mitigate these challenges.

### Steps for accelerated action

- Develop comprehensive strategies to tackle the health impacts of air pollution at the regional, country and local levels.
- Develop/strengthen communication strategies to raise awareness and stimulate demand for policies to tackle air pollution, prevent associated diseases and thus improve well-being at regional, country and local levels.
- Develop interventions to address air pollution and health in other relevant regional processes related to health, environment and sustainable development.
- Include air pollution reduction in regional and national public health programmes and strategies, for example in NCD prevention plans.
- Develop national tools to support implementation of WHO air quality guidelines as relevant and the implementation of national and subnational action plans on air pollution and health.
- Build Region-specific evidence on the impact of air pollution on health in the Eastern Mediterranean by strengthening data collection, conducting good quality epidemiological studies using standardized assessments for various air pollutants and relevant economic evaluation studies.

### Available guidance/tools

- EM/RC64/INF.DOC.3. Progress report on the regional plan of action for implementation of the roadmap for an enhanced global response to the adverse health effects of air pollution. 2017 ([https://applications.emro.who.int/docs/RC\\_technical\\_papers\\_2017\\_inf\\_doc\\_3\\_20013\\_en.pdf?ua=1](https://applications.emro.who.int/docs/RC_technical_papers_2017_inf_doc_3_20013_en.pdf?ua=1))
- WHO global air quality guidelines: particulate matter (PM<sub>2.5</sub> and PM<sub>10</sub>), ozone, nitrogen dioxide, sulfur dioxide and carbon monoxide. 2021 (<https://www.who.int/publications-detail-redirect/9789240034228>)
- WHO Guidelines for indoor air quality: Household fuel combustion. 2014 (<https://www.who.int/publications/i/item/9789241548885>)

- Compendium of WHO and other UN guidance on health and environment, 2022 update (<https://www.who.int/tools/compendium-on-health-and-environment>)
- The WHO Data Integration Model for Air Quality (DIMAQ) [online database]. (<https://www.who.int/data/gho/data/themes/air-pollution/who-modelled-estimates-of-air-pollution-from-particulate-matter>)
- AirQ+: software tool for health risk assessment of air pollution (<https://www.who.int/tools/airq#:~:text=AirQ%2B%3A%20software%20tool%20for%20health%20risk%20assessment%20of,short-%20and%20long-term%20exposure%20to%20ambient%20air%20pollution>)

### Key references

- Accelerating regional implementation of the Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, 2018. Regional Committee for the Eastern Mediterranean. Sixty-sixth session. Provisional agenda item 3(e). EM/RC66/7. September 2019 ([https://applications.emro.who.int/docs/RC\\_Technical\\_Papers\\_2019\\_7\\_en.pdf](https://applications.emro.who.int/docs/RC_Technical_Papers_2019_7_en.pdf))
- Arab Strategy and Framework of Action on Health and Environment 2017–2030. A regional strategy on health and environment for Arab states and an action guideline. League of Arab States in collaboration with WHO and the United Nations Environment Programme. Amman, Jordan 2017 [News] (<https://www.emro.who.int/ceha/ceha-news/summit-of-arab-league-adopts-arab-strategy-on-health-and-the-environment.html>)

### Data sources

- WHO Global Health Observatory. Indicator 3.9.1: Mortality rate attributed to household and ambient air pollution (per 100 000 population, age-standardized) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/ambient-and-household-air-pollution-attributable-death-rate-\(per-100-000-population-age-standardized\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/ambient-and-household-air-pollution-attributable-death-rate-(per-100-000-population-age-standardized)))



**Indicator 3.9.2: Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe water, sanitation and hygiene (WASH) services)**

Pakistan (38.8 deaths per 100 000 population) and Somalia (99.2 deaths per 100 000 population) bore the heaviest mortality burden in the Region in 2019.

**Current situation**

- In 2019, the mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene in the Region ranged from 0.4 deaths per 100 000 population in Qatar to 99.2 deaths per 100 000 population in Somalia.
- The mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene in 2019 was greater than 3.1 deaths per 100 000 population in half of the countries in the Region.
- Yemen (15.6 deaths per 100 000 population), Sudan (15.8 deaths per 100 000 population), Afghanistan (16.6 deaths per 100 000 population), Djibouti (37.6 deaths per 100 000 population),

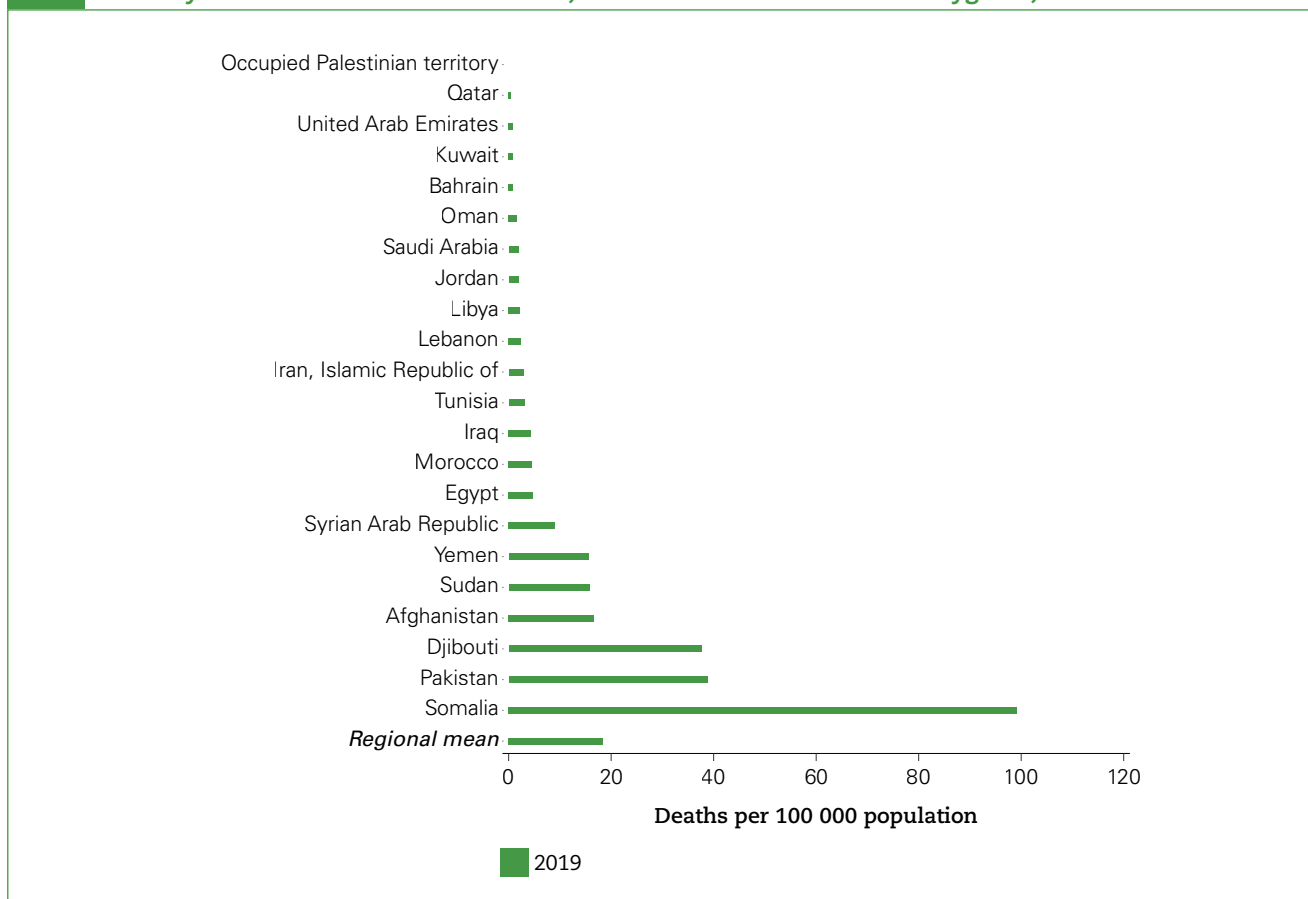
**Key message**

- Develop and implement a multisectoral programme to end open defecation, promote use of innovative technologies in safe drinking water and sanitation services, strengthen the regulatory framework and increase resource allocation.

**Challenges**

- The high mortality rates in Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen, corresponding to poor sanitation, drinking-water and hygiene coverage in these countries. As of 2020, the total number of people in the Region practicing open defecation was around 42.4 million (5.8% of the population of the Region); the total number of people in the Region lacking basic sanitation was around 159 million (22% of the population).

**3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene, 2010–2019**



- Climate change, increasing water scarcity, infrastructural interventions which modify the natural environment (e.g. dams), population growth, demographic changes, urbanization, and conflict and civil unrest, particularly in low-income countries of the Region.
- Inadequate or inappropriately managed water and sanitation services expose individuals to preventable health risks, and there is a lack of basic infrastructure for safe water in conflict-affected and crisis areas of the Region.
- Despite increased data on water and sanitation services (including in health-care facilities), gaps in data still exist, undermining advocacy and implementation efforts.
- Based on the latest progress report on WASH in health-care facilities in the Region, 73% of facilities had basic water services, 29% had basic sanitation services, 59% had basic hygiene services, 23% had basic health-care waste management services and 36% had basic environmental cleaning services.

### Steps for accelerated action

- Invest in improving water, sanitation and hygiene services in Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen.
- Continue to conduct national assessments of the availability and quality of water, sanitation and hygiene services in health-care facilities as a basis for establishing standards and developing a road map for improvement, including in emergency settings.

### Available guidance/tools

- Water sanitation and health. Water safety and quality [website] (<https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health/water-safety-and-quality>) including WHO guidelines on drinking-water quality and other related guidance.
- Water sanitation hygiene. Sanitation and wastewater [website] (<https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health>) including the WHO Guidelines on sanitation and health (<https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health/sanitation-safety/guidelines-on-sanitation-and-health>) and other related guidance.

### Key references

- Progress on household drinking water, sanitation and hygiene 2000–2020: five years into the SDGs. Geneva: WHO and UNICEF; 2021 (<https://washdata.org/reports/jmp-2021-wash-households>)
- Progress on WASH in health care facilities 2000–2021: special focus on WASH and infection prevention and control (IPC). WHO and UNICEF; 2022 (<https://washdata.org/reports/jmp-2022-wash-hcf>)
- WHO/UNICEF Joint Monitoring Programme [online database] ([www.washdata.org](http://www.washdata.org))

### Data sources

- WHO Global Health Observatory. Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population) (SDG 3.9.2) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/mortality-rate-attributed-to-exposure-to-unsafe-wash-services-\(per-100-000-population\)-\(sdg-3-9-2\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/mortality-rate-attributed-to-exposure-to-unsafe-wash-services-(per-100-000-population)-(sdg-3-9-2)))

**Indicator 3.9.3: Mortality rate attributed to unintentional poisoning**

**Current situation**

- There were negligible changes in the mortality rate attributed to unintentional poisoning in most of the countries in the Region over the period 2015–2019.
- The median mortality rate attributed to unintentional poisoning in the Region declined slightly from 0.9 deaths per 100 000 population in 2010 to 0.7 deaths per 100 000 population in 2019.
- In 2019, the mortality rate attributed to unintentional poisoning in the Region ranged from 0.2 deaths per 100 000 population in Egypt to 4.9 deaths per 100 000 population in Somalia.
- In 2019, the mortality rate attributed to unintentional poisoning was below 1 death per 100 000 population in 15 countries of the Region

but not Afghanistan (1.0 deaths per 100 000 population), Pakistan (1.6 deaths), Sudan (1.7), Yemen (1.8) Djibouti (2.5) and Somalia (4.9 deaths per 100 000 population).

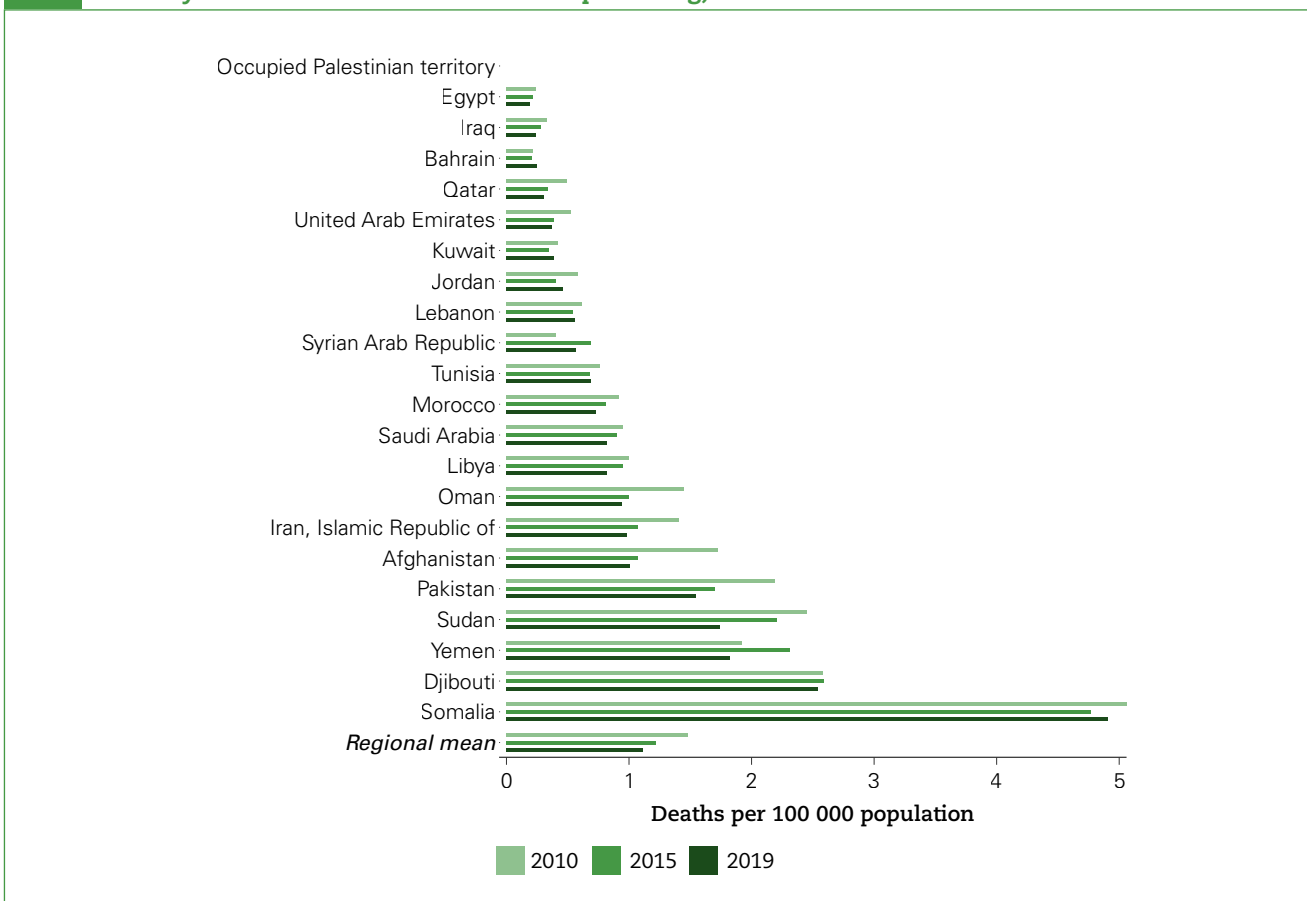
**Key message**

- Ensure health sector implementation of the Chemicals Road Map by strengthening regulatory frameworks to limit access to highly toxic pesticides, establishing and strengthening poison centres, and integrating poisoning within surveillance systems.

**Challenges**

- There are few functional national poison control centres in the Region.
- Many event and syndromic surveillance systems do not capture information on poisoning.
- Limited public health laboratory capacity to detect chemical poisoning.

**3.9.3 Mortality rate attributed to unintentional poisoning, 2010–2019**



## Goal 3

- Limited awareness of chemical poisoning among agricultural and industrial workers, and among households and families.
- Poison centre services are not integrated with public health/emergency services.

### Steps for accelerated action

- Increase awareness of the sources of poisonings at household, agricultural and industrial levels.
- Integrate poison centres with the national IHR networks.
- Strengthen the regulatory framework to limit the availability of, and access to, highly toxic pesticides and other hazardous chemicals.
- Establish/strengthen event and syndromic surveillance systems to collect and report data on poisonings at national and subnational levels.
- Strengthen public health laboratory capacity to detect chemical poisoning.
- Establish functioning poison centre(s) that serve the whole country 24/7.

### Available guidance/tools

- The WHO Global Chemicals and Health Network ([https://cdn.who.int/media/docs/default-source/chemical-safety/chemicals-flyer-eng-13082020-web.pdf?sfvrsn=ae81d81c\\_33&download=true](https://cdn.who.int/media/docs/default-source/chemical-safety/chemicals-flyer-eng-13082020-web.pdf?sfvrsn=ae81d81c_33&download=true))

- Chemicals road map. Road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond. 2017 (<https://www.who.int/publications/i/item/WHO-FWC-PHE-EPE-17.03>)
- Concise International Chemical Assessment Documents (CICADs) [website] (<https://www.inchem.org/pages/cicads.html>)

### Key references

- WHO Guidelines for establishing a poison centre. 2021 (<https://www.who.int/publications/i/item/9789240009523>)
- Guidelines on the prevention of toxic exposures. Education and public awareness activities. Geneva: World Health Organization; 2004. Published by WHO in collaboration with the United Nations Environment Programme and the International Labour Organization (<https://www.who.int/publications/i/item/9241546115>)
- Compendium of WHO and other UN guidance on health and environment, 2022 update (<https://www.who.int/publications/i/item/WHO-HEP-ECH-EHD-22.01>)

### Data sources

- WHO Global Health Observatory. Poison control and unintentional poisoning (<https://www.who.int/data/gho/data/themes/topics/indicator-groups/poison-control-and-unintentional-poisoning>)

**Target 3.a:** Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

**Indicator 3.a.1: Age-standardized prevalence of current tobacco use among persons aged 15 years and older**

**Current situation**

- In 2019, the age-standardized prevalence of current tobacco use among persons aged 15 years and older in the Region ranged from 8.0% in Oman to 39.0% in Lebanon.
- Median age-standardized prevalence of current tobacco use among persons aged 15 years and older in the Region in 2019 was 21.3%, with seven countries (Afghanistan, Egypt, Iraq, Kuwait, Lebanon, Tunisia and Yemen) having rates above the median.

- Age-standardized prevalence of current tobacco use among persons aged 15 years and older in all countries in the Region was higher among men than women.
- Prevalence of current tobacco use among adolescents aged 13–15 years in the Region in 2019 was 15.6% among boys and 8% among girls; boys’ rates were the highest of the six WHO regions.

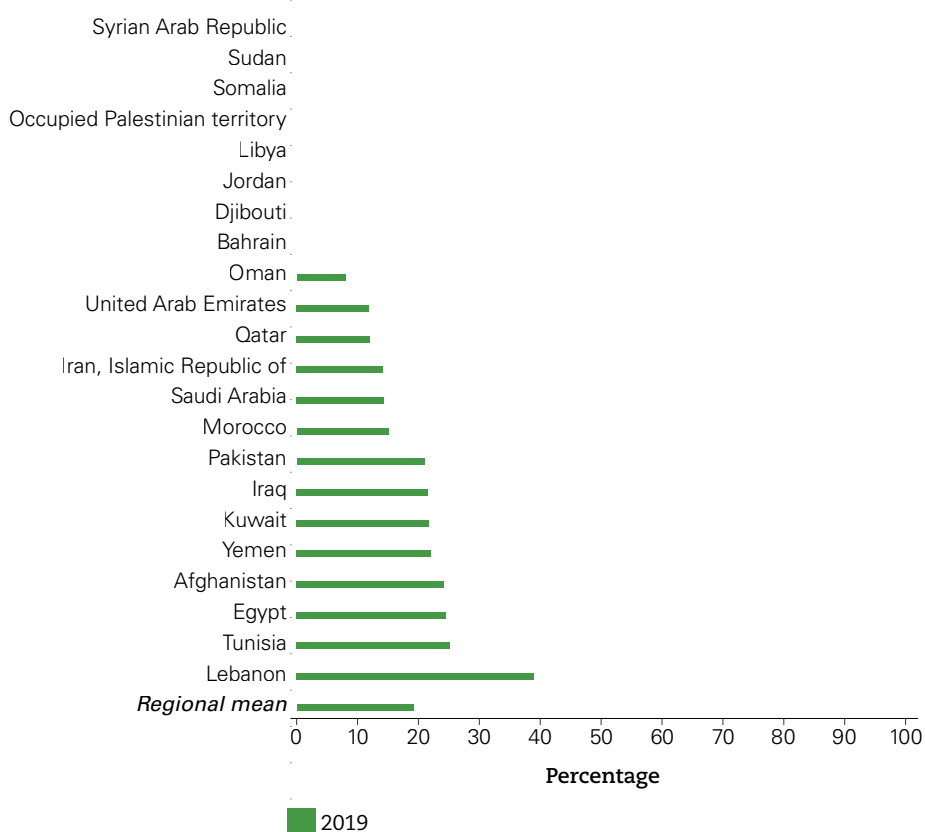
**Key message**

- Although all countries of the Region but Morocco and Somalia are Parties to the WHO Framework Convention on Tobacco Control (FCTC), a much stronger multisectoral approach is needed to enact and enforce recommended tobacco-control policies from the FCTC, MPOWER and NCD best buys, especially in addressing affordability as the Region has the lowest average price of tobacco products globally.

**Challenges**

- The Region is likely to experience an increase in the number of tobacco users due to population

**3.a.1 Prevalence of tobacco use among persons 15 years and older, 2019**



**Goal  
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growth together with the increasing rates of consumption and uptake of tobacco products, especially among youth, despite some countries having shown progress in implementing the WHO FCTC and the WHO recommended interventions (MPOWER).

- Lack of regular data collection at national level and significant gaps between surveillance rounds for adults and young people due in part to the emergency situation in many countries as well as the COVID-19 pandemic.
- Competing health priorities that push back the tobacco-control agenda, either due to unrest or health emergencies such as the pandemic.
- Growing popularity of emerging nicotine and tobacco products (ENDS and ENNDS) including e-cigarettes and heated tobacco products.
- Tobacco industry activities that undermine tobacco control at national level.

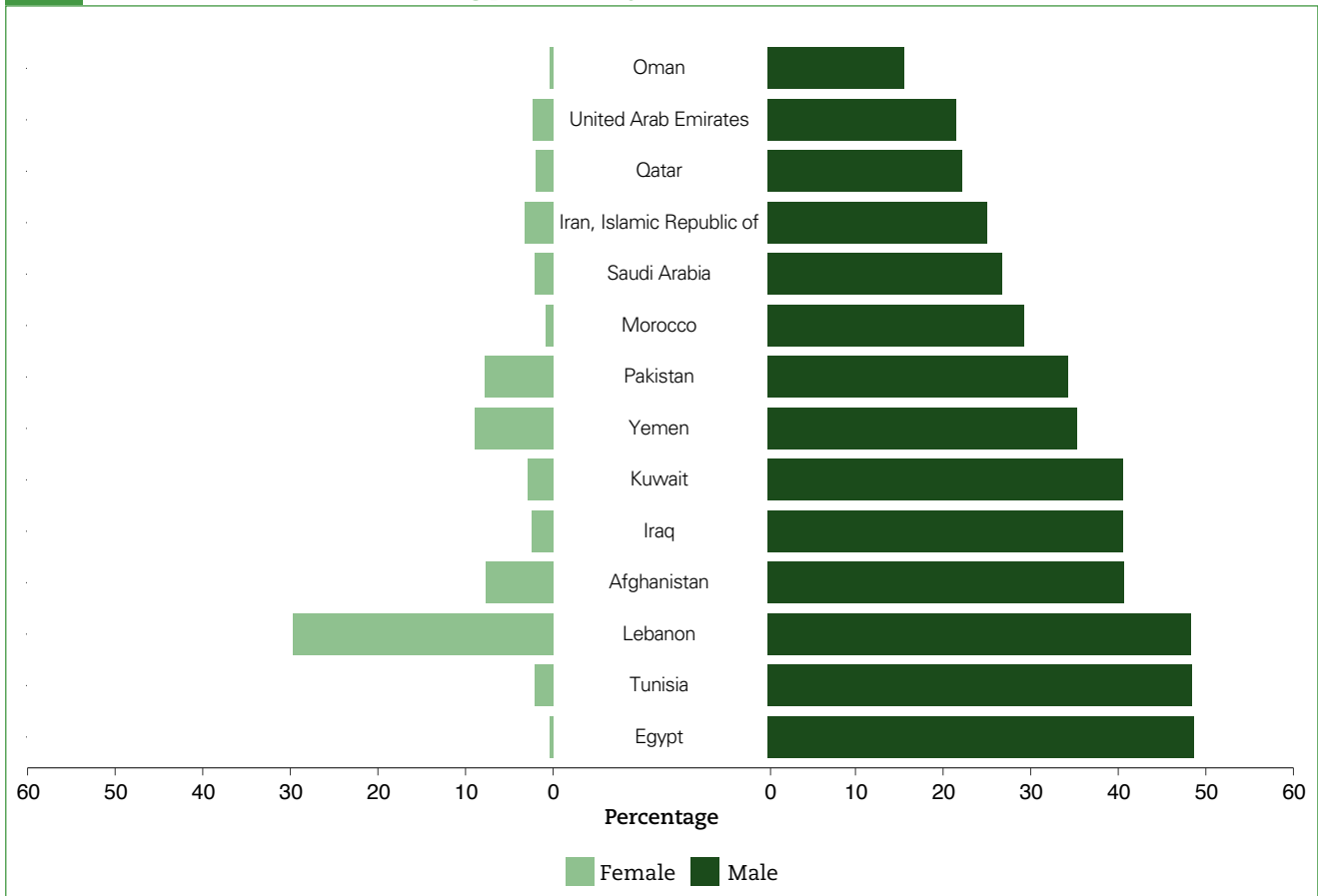
**Steps for accelerated action**

- Adopt a multisectoral national plan of action that aligns to recommended tobacco control policies and public health actions.
- Identify and address legislative gaps to achieve the highest level of implementation of every tobacco-control policy of the WHO FCTC, MPOWER and NCD best buys.
- Continue to monitor tobacco use trends and progress on implementing the WHO FCTC.
- Regulate all emerging nicotine and tobacco products.
- Strengthen enforcement and implementation of existing legislation at country level.

**Available guidance/tools**

- The WHO Framework Convention on Tobacco Control (FCTC). Guidelines, policy options and recommendations for implementation of the WHO FCTC (<https://fctc.who.int/publications/item/9241591013>)

**3.a.1 Prevalence of tobacco use among persons 15 years and older, 2019**



- Regional strategy and action plan for tobacco control 2019–2023. WHO Regional Office for the Eastern Mediterranean (<https://apps.who.int/iris/handle/10665/331952>)
- Regional framework for action on tobacco control. WHO Regional Office for the Eastern Mediterranean. 2019 (<https://apps.who.int/iris/handle/10665/325837>)
- WHO Tobacco Free Initiative [website] (<https://www.who.int/health-topics/tobacco>)
- Regional Tobacco Free Initiative resources [website] (<http://www.emro.who.int/entity/tobacco-free-initiative/index.html>)
- Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva: World Health Organization; 2013 (<https://www.who.int/publications/i/item/9789241506236>)
- The economics of tobacco and tobacco control. NCI Tobacco Control Monograph Series 21. US National Cancer Institute and World Health Organization. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; and Geneva: World Health Organization; 2016 (<https://cancercontrol.cancer.gov/brp/tcrb/monographs/monograph-21>)
- WHO report on the global tobacco epidemic 2021: addressing new and emerging products., Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240032095>)
- WHO Regional Committee for the Eastern Mediterranean. Accelerating regional implementation of the Political Declaration of the Third High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, 2018. World Health Organization: Cairo; 2019 (<https://apps.who.int/iris/handle/10665/371121>)

### Key references

- WHO report on the global tobacco epidemic 2019: offer help to quit tobacco use. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/i/item/9789241516204>)
- Global Youth Tobacco Survey and Global Adult Tobacco Survey [online databases]. In: WHO. Noncommunicable Disease Surveillance, Monitoring and Reporting. Population-based surveys [webpage] (<https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools>)
- WHO global report on trends in prevalence of tobacco use 2000–2025. Third Edition. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/i/item/who-global-report-on-trends-in-prevalence-of-tobacco-use-2000-2025-third-edition>)

### Data sources

- WHO Global Health Observatory. Age-standardized estimates of current tobacco use, tobacco smoking and cigarette smoking (Tobacco control: Monitor) (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-tobacco-control-monitor-current-tobaccouse-tobaccosmoking-cigarrettesmoking-agestd-tobagestdcurr>)

Goal  
3

**Target 3.b:** Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

**Indicator 3.b.1: Proportion of the target population covered by all vaccines included in their national programme**

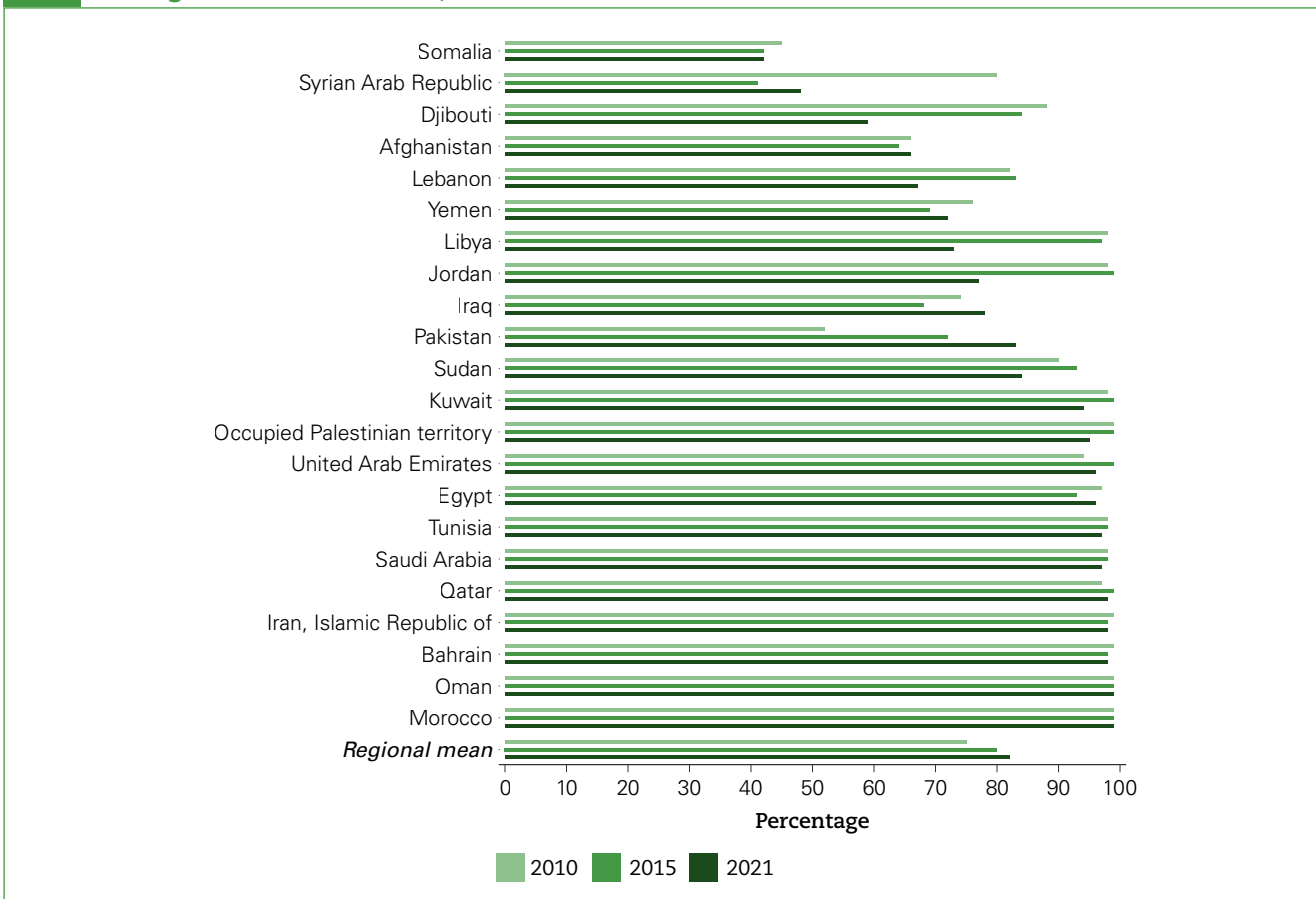
**Current situation**

- In 2021, the percentage of surviving infants who received the third dose of a diphtheria-tetanus-pertussis containing vaccine (DTP3) across the

Region was 82%. National levels ranged from 42% in Somalia to 99% in Oman and Morocco.

- There was a fall in the number of countries achieving 95% or more DTP3 coverage in the Region from 13 countries in 2015 to 10 countries in 2021.
- Between 2010 and 2021, the percentage of surviving infants who received DTP3 vaccine declined in 15 countries of the Region with the largest drops in Syrian Arab Republic (from 80% in 2010 to 48% in 2021) and Djibouti (from 88% in 2010 to 59% in 2021).
- Overall, the percentage of surviving infants who received DTP3 vaccine in the Region increased from 75% in 2010 to 80% in 2015 and 82% in 2021.
- In 2021, the percentage of surviving infants who received DTP3 vaccine was at least 95% in 11 countries of the Region.
- In 2021, 77% of children in the Region received two doses of measles-containing vaccine (MCV2) in a given year according to the nationally recommended schedule. National figures ranged from 4% in Somalia to 99% in Bahrain, Morocco, Oman and Qatar.

**3.b.1 Coverage of DTP3 vaccination, 2010–2021**





- In 2021, 10 countries had at least 95% coverage of MCV2.
- Between 2010 and 2021, the percentage of children who received MCV2 declined in eight countries of the Region with the largest reductions in Syrian Arab Republic (from 82% in 2010 to 53% in 2021) and Libya (from 97% in 2010 to 72% in 2021).
- Overall, the mean value for MCV2 in the Region increased slightly from 52% in 2010 to 68% in 2015 and 77% in 2021.
- In 2021, the percentage of one-year-olds who received a third dose of pneumococcal conjugate (PCV3) vaccine was 54%. This represents a jump from 5% in 2010 but only a modest increase from 51% in 2015. National figures ranged from 0% in Iraq to 99% in Bahrain and Oman.
- In 2021, among countries with data, nine countries had at least 95% coverage for PCV3.

### Key message

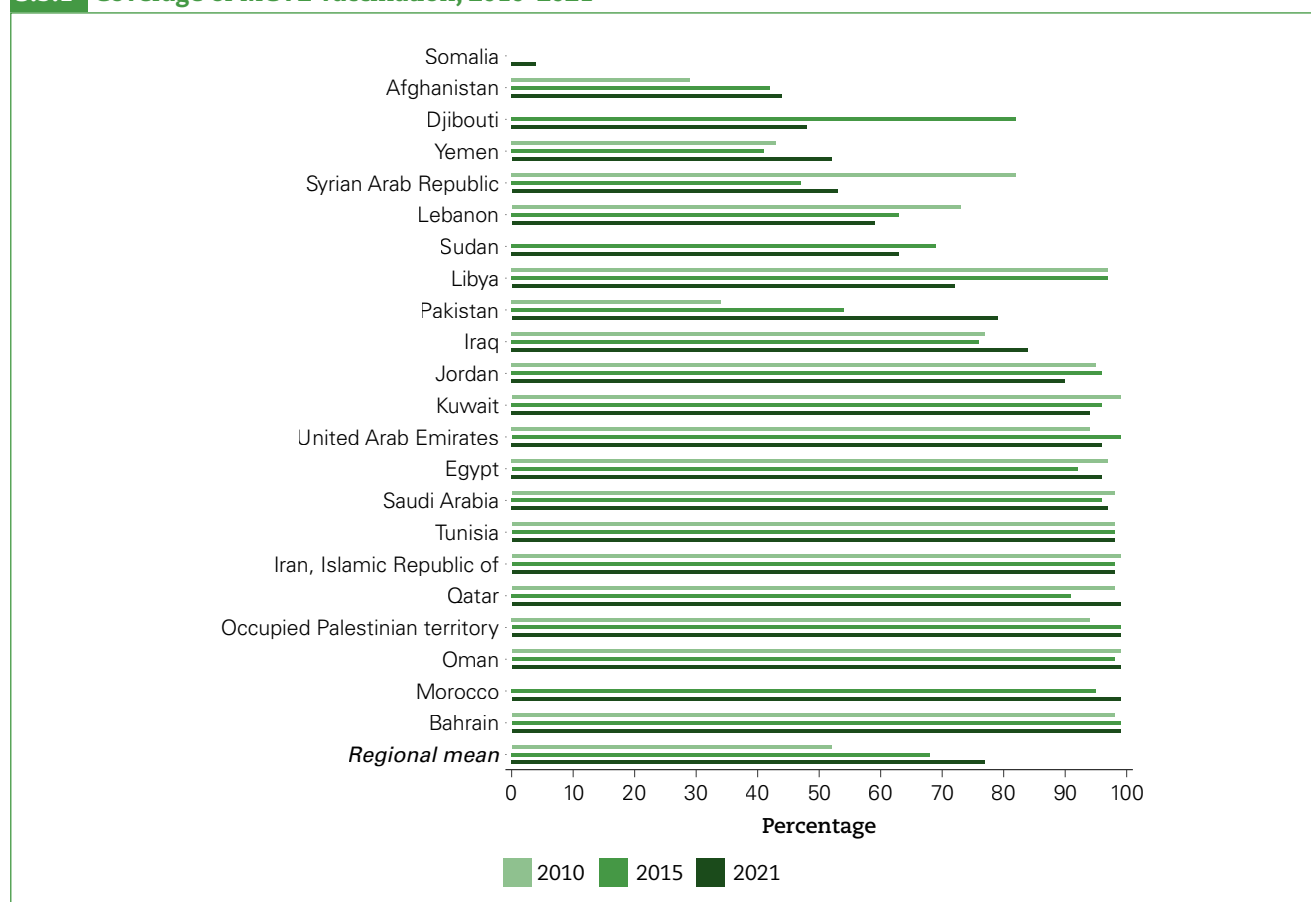
- Secure sustainable investment to strengthen all components of the health system for implementing a strong national immunization

policy, including the safe introduction of new lifesaving vaccines of public health importance in both stable and fragile or vulnerable settings.

### Challenges

- Limited access to immunization services for marginalized and vulnerable populations. Conflict, humanitarian emergencies, insecurity and geographical barriers are hampering the implementation of planned activities, especially outreach and mobile vaccine delivery and supplementary immunization campaigns.
- Absence of adequate and sustainable public investment for immunization and high donor dependence.
- Non-Gavi eligible middle-income countries have not yet introduced new lifesaving vaccines of public health importance (e.g. PCV, rotavirus vaccine, HPV) due to financial constraints and lack of prioritization.
- Some countries lack a strong and transparent policy and process for selection and procurement of vaccine products for the national programme.
- Weak data to identify needs and monitor programme implementation and outcomes. This

### 3.b.1 Coverage of MCV2 vaccination, 2010–2021



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includes poor disease surveillance and inadequate data on the inputs, process and outputs of the immunization programme, especially at the subnational level where denominators are often unreliable and inconsistent.

**Steps for accelerated action**

- Strengthen all components of the health system, including governance and accountability.
- Secure adequate and sustainable public investment for the national immunization programme.
- Develop and implement a strong national immunization policy.
- Improve capacity for evidence-based decision-making on the introduction of essential vaccines in the national context, taking into account global recommendations.
- Create a transparent and efficient vaccine procurement system to ensure the availability of safe and effective vaccine products of assured quality at competitive prices for the national programme.

- Strengthen the health information system to better monitor and evaluate immunization programmes, including by broadening approaches to monitor the epidemiology of diseases targeted by vaccination, as well as inequities.

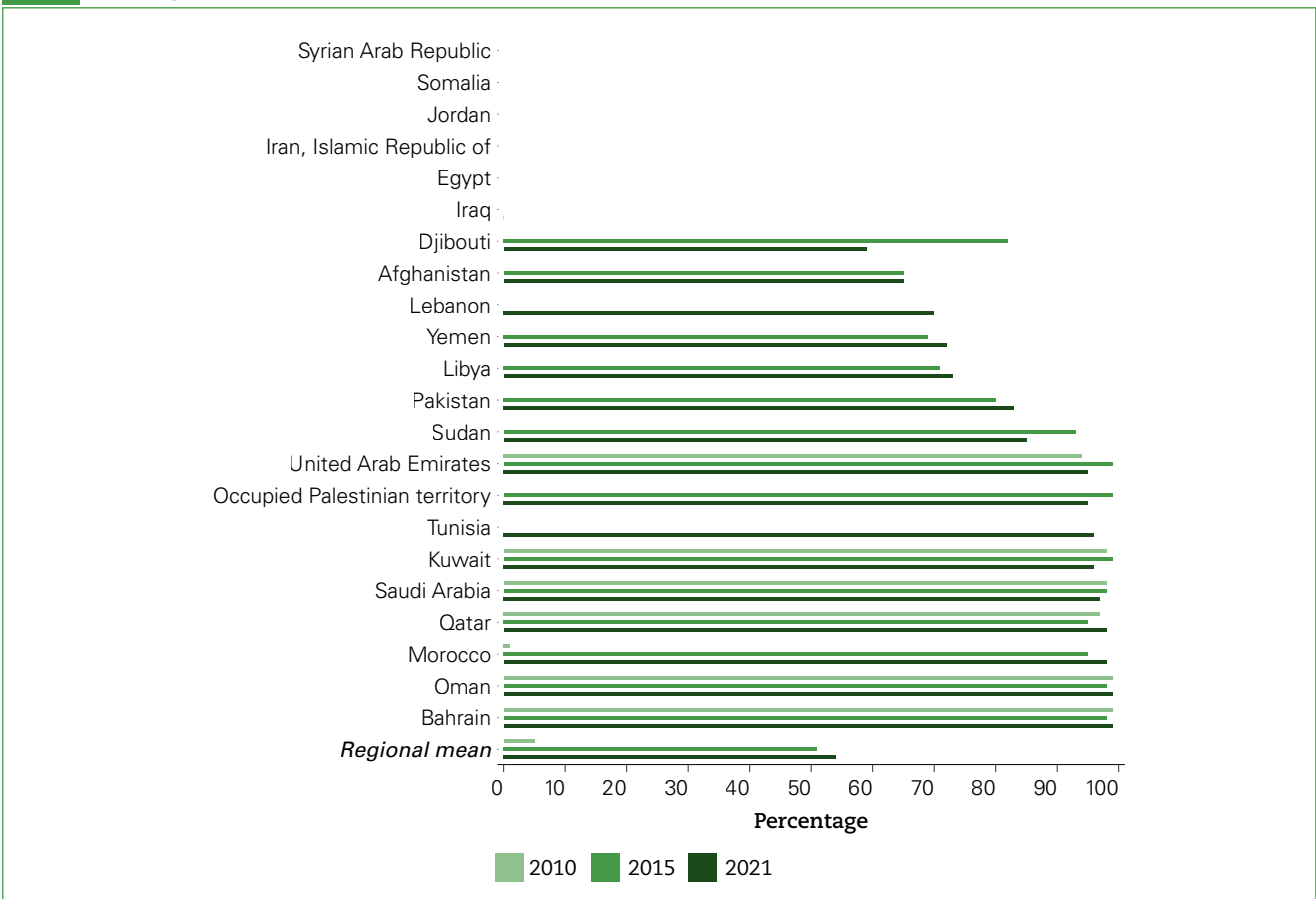
**Available guidance/tools**

- WHO vaccine position papers [website] (<https://www.who.int/teams/immunization-vaccines-and-biologicals/policies/position-papers>)
- Duclos P. National immunization technical advisory groups (NITAGs): guidance for their establishment and strengthening. Vaccine. 2010;28(Suppl. 1):A18–A25 (<https://pubmed.ncbi.nlm.nih.gov/20412991/>)
- A guide for conducting an Expanded Programme on Immunization (EPI) review. 2017 (<https://apps.who.int/iris/bitstream/handle/10665/259960/WHO-IVB-17.17-eng.pdf;sequence=1>)
- Immunization agenda 2030: a global strategy to leave no one behind. 2020 (<https://www.who.int/publications/m/item/immunization-agenda-2030-a-global-strategy-to-leave-no-one-behind>)

**Data sources**

- WHO immunization dashboard (<https://immunizationdata.who.int/>)

**3.b.1 Coverage of PCV3 vaccination, 2010–2021**



**Indicator 3.b.2: Total net official development assistance to medical research and basic health sectors per capita, by recipient countries (US\$)**

**Current situation**

- In 2021, official development assistance (ODA) to medical research and basic health sectors in the Region was US\$ 3.2 per capita, the second highest after the African Region (US\$ 4.1).
- Health ODA in the Region ranged from US\$ 0.8 per capita in Islamic Republic of Iran to US\$ 22.8 per capita in Lebanon.
- It should be noted that such estimates do not cover the intramural (domestic) funding of health research, which is a characteristic of the most populous countries of the Region such as Egypt, the Islamic Republic of Iran, Pakistan and Saudi Arabia.

**Key message**

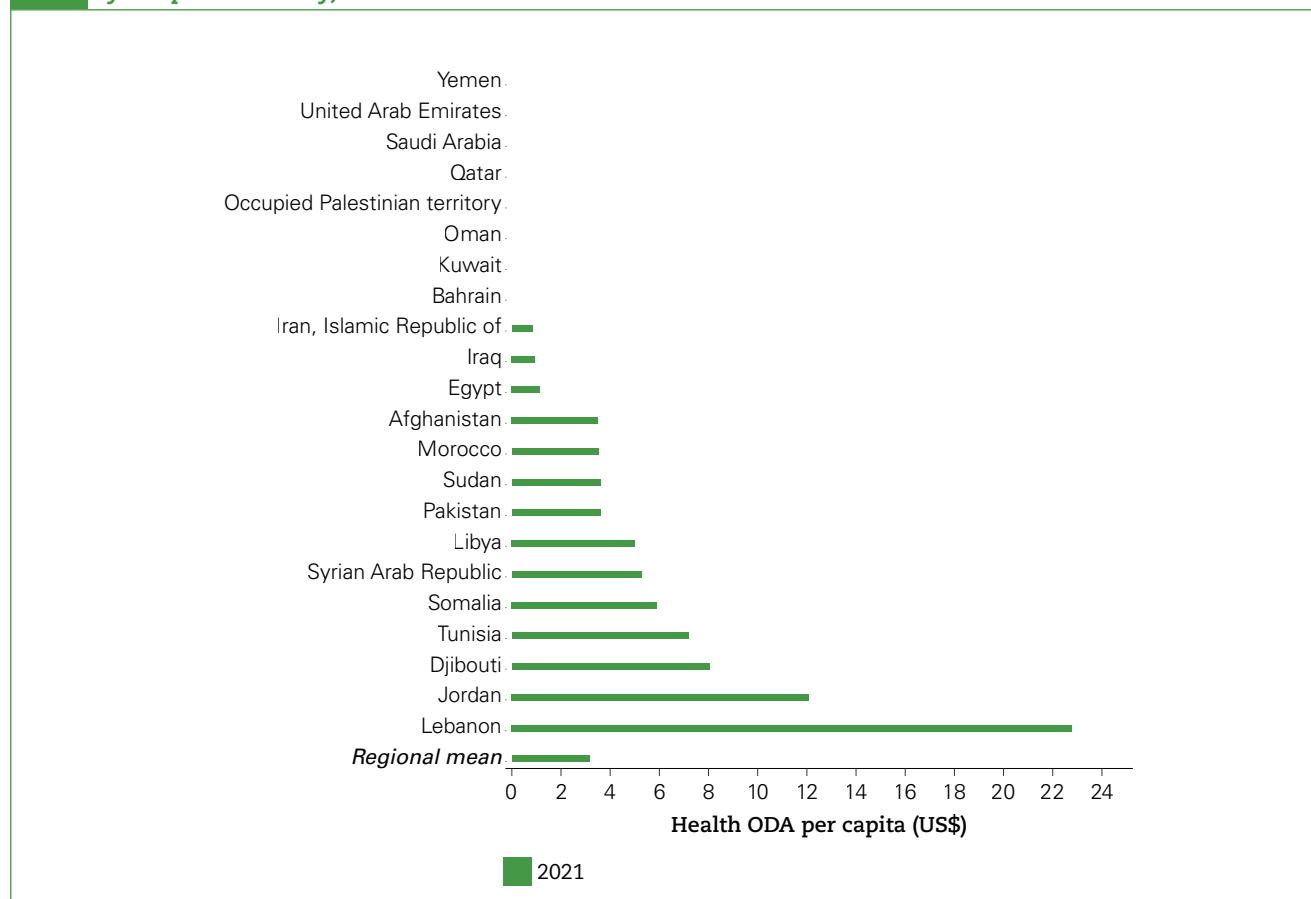
- Establish and implement or strengthen a national health research policy with appropriate political support and allocate adequate funding and human resources to health systems research.

**Challenges**

- The data source is the OECD/Development Assistance Committee (DAC), also quoted at the WHO Global Observatory on Health Research and Development, which provides a DAC list of ODA recipients in the Region<sup>1</sup>. This source may not accurately reflect the true progress made on indicator 3.b.2 in the Region.
- The Eastern Mediterranean Region has the highest weighted average of health ODA as a percentage of GNI of any WHO region based on data from 42 donor countries (0.039%).

<sup>1</sup> DAC List of ODA Recipients. Least developed countries: Afghanistan, Djibouti, Sudan and Yemen; Lower-middle income countries and territories: Egypt, Jordan, Pakistan and Syrian Arab Republic (and West Bank and Gaza Strip); Upper-middle income countries and territories: the Islamic Republic of Iran, Iraq, Lebanon and Libya. OECD. Development Assistance Committee (DAC) (<https://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/daclist.htm>, accessed 9 August 2023).

**3.b.2 Official development assistance (ODA) for medical research and basic health sectors per capita, by recipient country, 2021**



- The Region has the second highest health ODA per capita (US\$ 3.16) among the WHO regions based on data from 136 recipient countries.
- Of the voluntary national reviews submitted by 18 Eastern Mediterranean countries between 2015 and 2021, only two (occupied Palestinian territory and Tunisia) reported on this indicator.

### Steps for accelerated action

- In line with the Council on Health Research for Development, donor countries should consider committing a percentage of funds dedicated to health to supporting national health research and research capacity building.
- Countries should invest at least 2% of national health expenditures to support essential national health research.
- As an example, the United Kingdom is highlighting “total net official development assistance to medical research and basic health sectors” for this indicator<sup>2</sup> – which could also be adopted by some of the countries in the Region that are actively providing ODA to recipient countries in the Region or possibly in other WHO regions.
- It is recommended that countries in the Region undertaking voluntary national SDG reviews include indicator 3.b.2 to reflect the efforts being made in this area.

### Available guidance/tools

- A systematic approach for undertaking a research priority-setting exercise: guidance for WHO staff. 2020 (<https://apps.who.int/iris/handle/10665/334408>)
- The WHO strategy on research for health. 2012 (<https://www.who.int/publications-detail-redirect/9789241503259>)
- The World Health Report 2013. Research for universal health coverage (<https://www.who.int/publications/i/item/9789240690837>)
- Technical paper. Strategic directions for scaling up research for health in the Eastern Mediterranean Region (EM/RC58/6). 2011 (<https://apps.who.int/iris/handle/10665/122984>)

### Key references

- WHO Global Observatory on Health R&D [online database] (<https://www.who.int/observatories/global-observatory-on-health-research-and-development>)

### Data sources

- WHO Global Health Observatory. Total net official development assistance to medical research and basic health sectors per capita (US\$), by recipient country (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/total-net-official-development-assistance-to-medical-research-and-basic-health-sectors-per-capita>)

<sup>2</sup> Indicator 3.b.2. Total net official development assistance to medical research and basic health sectors. Office for National Statistics, United Kingdom (<https://sdgdata.gov.uk/3-b-2/>, accessed 9 August 2023).

**Indicator 3.b.3: Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis**

**Current situation**

- During the period 2019–2021, the availability of essential medicines in public and private health facilities was 100% in Bahrain, Jordan, Kuwait, Qatar and the United Arab Emirates.
- The availability of essential medicines in public health facilities was lowest in Libya (13%).
- The availability of essential medicines in public health facilities was more than 98.4% in six countries of the Region (Bahrain, Jordan, Kuwait, Qatar, Saudi Arabia and the United Arab Emirates).
- The availability of essential medicines in private health facilities was lowest in Tunisia (11.6%) and Libya (13%).

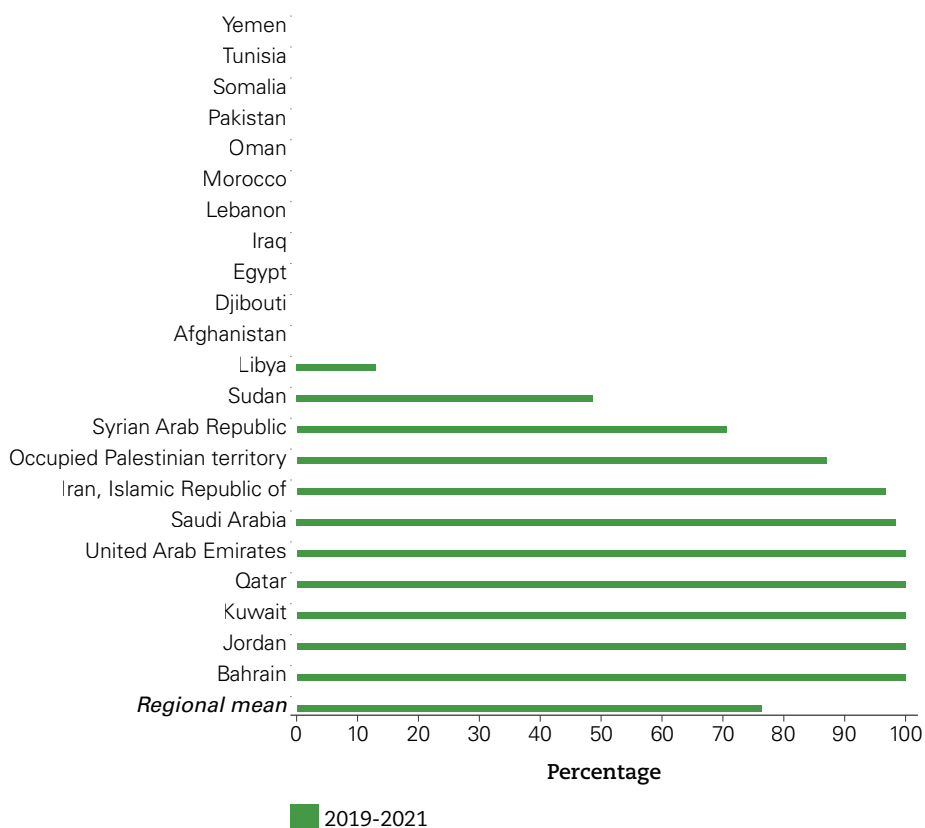
**Key message**

- Improve governance to ensure access to affordable quality essential medicines by implementing priority actions of the regional strategy relevant to the country context.

**Challenges**

- Although most countries have a national medicines policy, they lack regulatory procedures and supply chain management in case of emergencies and relevant implementation plans, and only half of countries in the Region have a list of essential medicines updated in the last two years.
- Half of medicines are prescribed or used irrationally, indicating limited regulatory measures to promote the rational use of medicines.
- No country in the Region can meet its public health need in terms of production of vaccines and few are investing in health technology assessment.

**3.b.3 Availability of essential medicines in public health facilities, 2019–2021**



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- Data-collection mechanisms (for example, health facility surveys and assessments, household surveys, disease-specific registries or databases, pharmaceutical sector country profiles) require human and financial resources that are not available in many countries of the Region.
- Despite the progress made on improving the availability and affordability of medicines, quality data on access to medicines is unavailable.
- Lack of automated systems to track the availability of medicines at health facilities in the Region.

### Steps for accelerated action

- Identify and secure needed technical and financial resources to support countries in strengthening their national health and pharmaceutical information systems, with a focus on improving the collection, analysis and use of data on access to medicines.
- Identify key strategic areas for the development of a technical package on measurement of access to medicines in the Region.
- Build country capacity to collect, analyse and use data on access to medicines.

### Available guidance/tools

- Measuring medicine prices, availability, affordability and price components. Second edition. Geneva: World Health Organization and Health Action International; 2008 (<https://apps.who.int/iris/handle/10665/70013>)
- Service availability and readiness assessment (SARA) [webpage] (<https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-sara>)

- WHO MedMon App – WHO Essential Medicines and Health Products Price and Availability Monitoring Mobile Application (<https://www.who.int/news/item/18-02-2018-medmon-mobile-application>)
- Monitoring the components and predictors of access to medicines. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/m/item/monitoring-the-components-and-predictors-of-access-to-medicines>)

### Key references

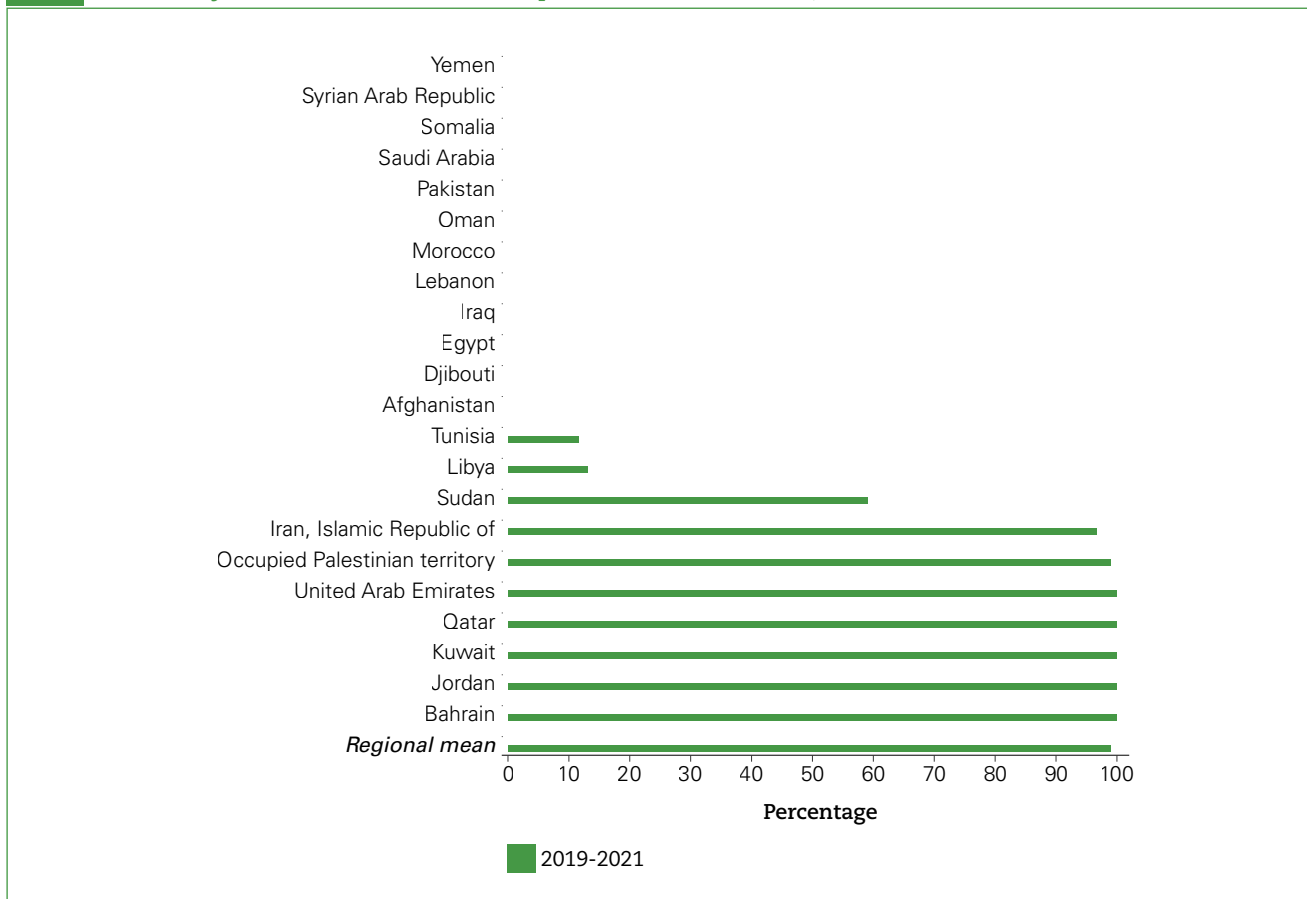
- Regional strategy to improve access to medicines and vaccines in the Eastern Mediterranean, 2020–2030, including lessons from the COVID-19 pandemic. Regional Committee for the Eastern Mediterranean. Sixty-seventh session. Provisional agenda item4(a). EM/RC67/6. October 2020 (<https://apps.who.int/iris/handle/10665/335952>)

### Data sources

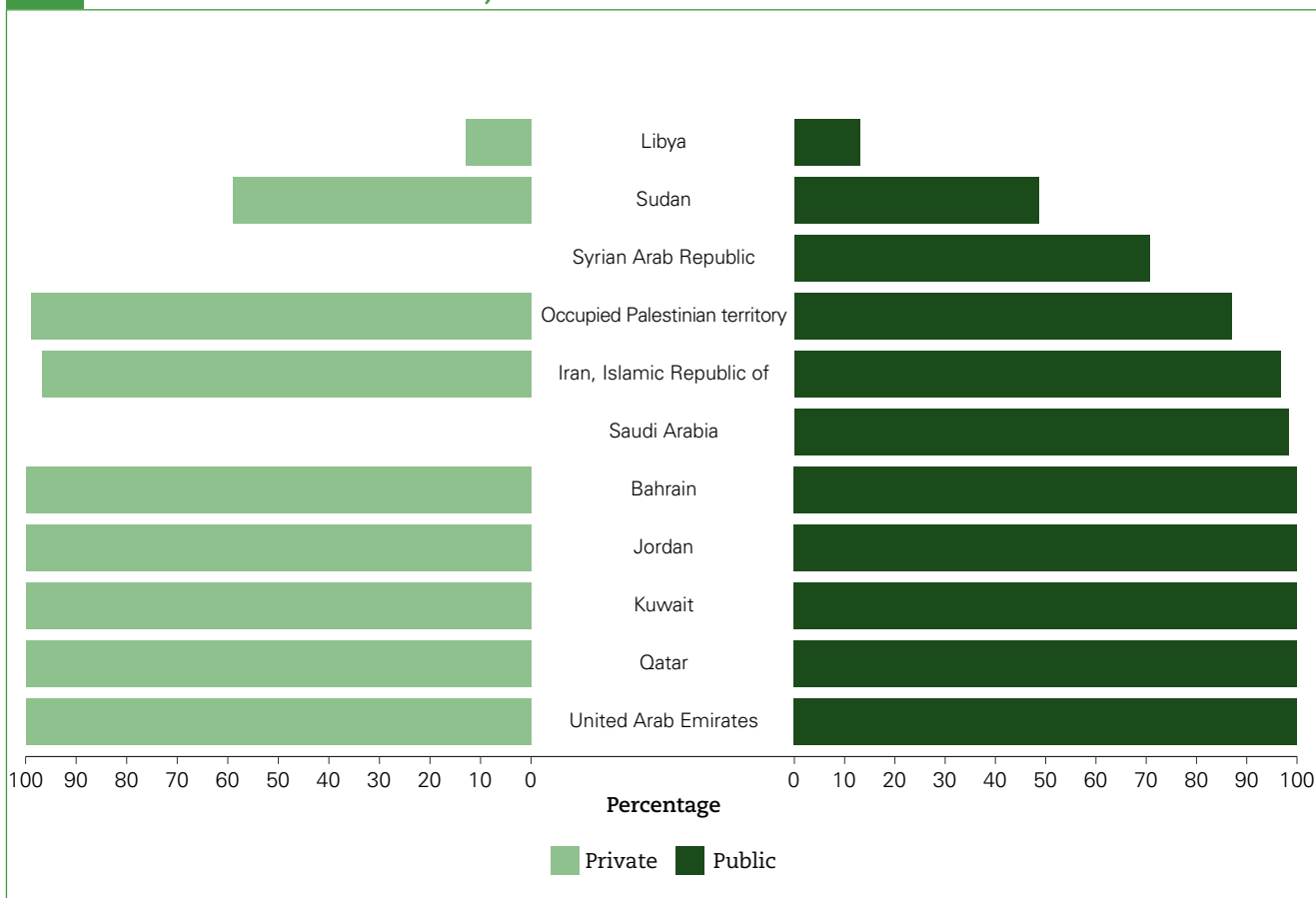
- Eastern Mediterranean Health Observatory. Availability of selected essential medicines in public and private health facilities (<https://rho.emro.who.int/Indicator/TermID/85>)

**Target 3.c:** Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

### 3.b.3 Availability of essential medicines in private health facilities, 2019-2021



### 3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis, 2017-2021



**Indicator 3.c.1: Health worker density and distribution**

**Current situation**

- There were only modest changes in the density of physicians, nurses and midwives, pharmacists and dentists in most countries of the Region between the periods 2013–2015 and 2018–2020.
- Six countries in the Region (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen) are facing the most pressing health workforce challenges related to universal health coverage and have a health workforce density below the global median of 49 per 10 000 population and a UHC service coverage index of less than 55.1 (see indicator 3.8.1). For this reason, they are included in the WHO Health Workforce Support and Safeguards List consisting of 55 countries from all WHO regions facing the most pressing health workforce

challenges related to universal health coverage.

- Recent data was not available for Djibouti and scarce for Somalia.

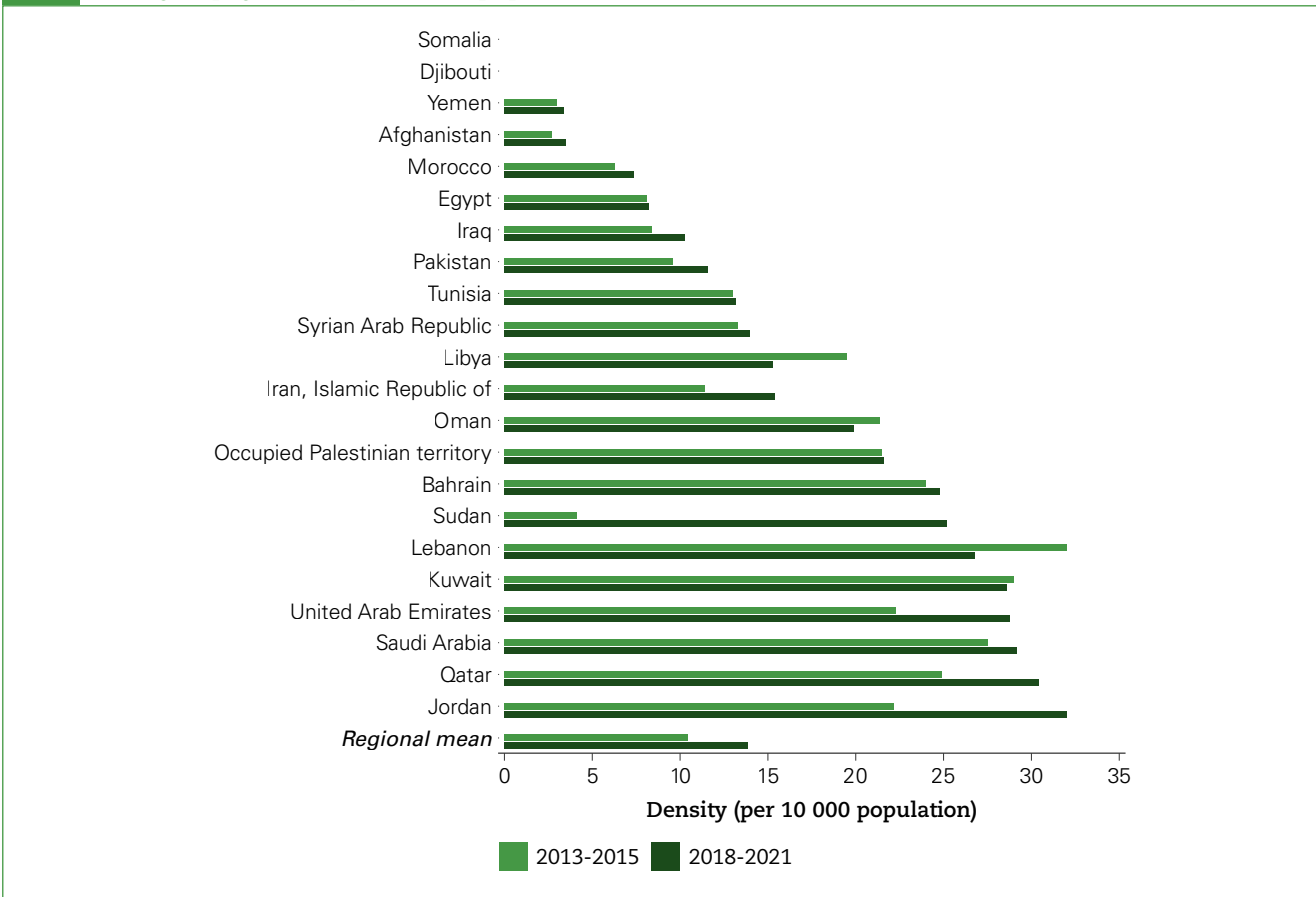
**Key message**

- Invest in the development and employment of health workers to address the needs of the national health system. This includes creating employment opportunities and improving working conditions.

**Challenges**

- The suboptimal development and availability of the health workforce, and imbalances in its skill mix and geographical distribution, are challenges faced by a majority of countries in the Region.
- Low availability of multidisciplinary primary care workforce and health workforce required to support the delivery of essential public health functions, as well as emergency preparedness and response.
- Inadequate education and training capacities feed concerns over the quality and relevance and of both the existing and future health workforce. The changing burden of disease, rapidly advancing technologies and digital transformation have significant implications for future health workforce

**3.c.1 Density of physicians per 10 000 population, 2013-2021**





requirements in terms of how health workers are educated and trained.

- Limited employment capacities together with increasing retention challenges and the international mobility of health professionals are growing concerns for countries across the Region.
- Limited capacities for health workforce governance and regulation.
- Weak and fragmented health workforce information systems are particularly challenging in the Region and face data quality and periodicity challenges. Additionally, available health workforce data tend to be mostly for the public sector, with limited information on the active workforce in other sectors. There are also discrepancies between the active and reported workforce due to fragmented and non-updated databases.
- The safety, security and well-being of health workers is a challenge, including safe and healthy working environments, employment security and

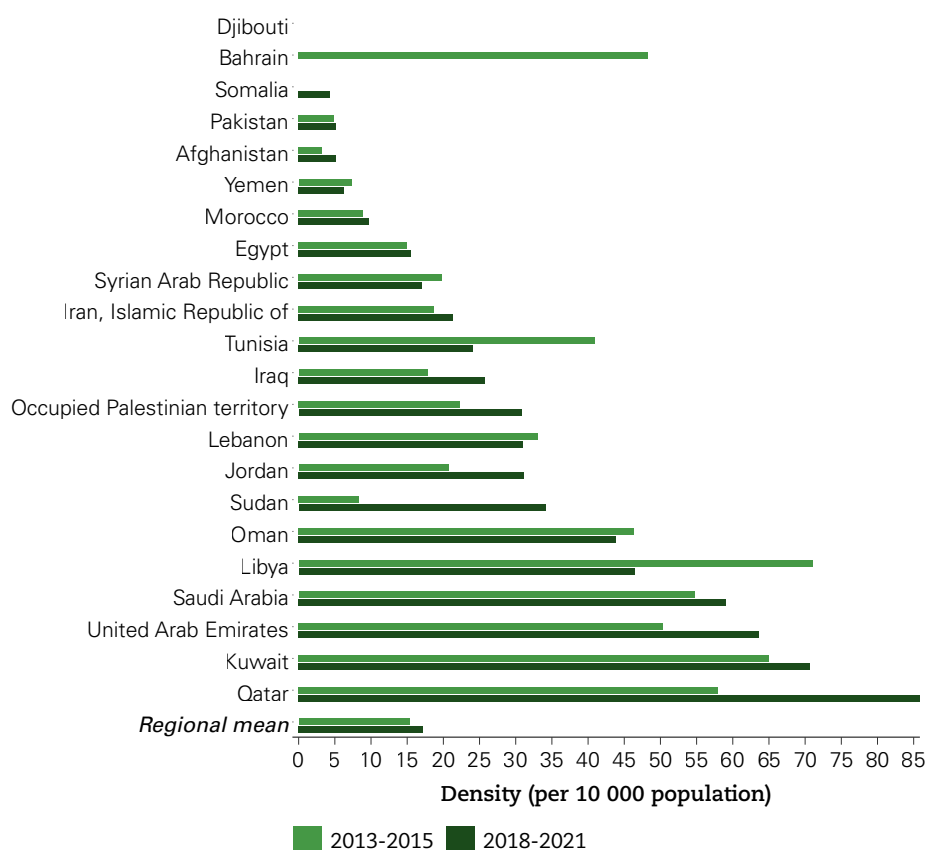
adequate and regular remuneration.

### Steps for accelerated action

At a Regional Meeting on Health Workforce held on 19–20 June 2023, it was proposed that the Regional Committee issue a call to action at the halfway point toward the SDGs in 2030. The following actions were proposed:

- Increase and sustain investment in the production and employment of health workers with better alignment with the needs of health systems, as well as creating employment opportunities and improved working conditions.
- Develop and implement comprehensive health workforce policies and strategic plans based on health labour market analysis, encompassing production, recruitment, employment as well as managing attrition.
- Strengthen the capacity of health workforce governance structures at all levels and regulation of health workforce practices and education.

### 3.c.1 Density of nurses and midwives per 10 000 population, 2013-2021



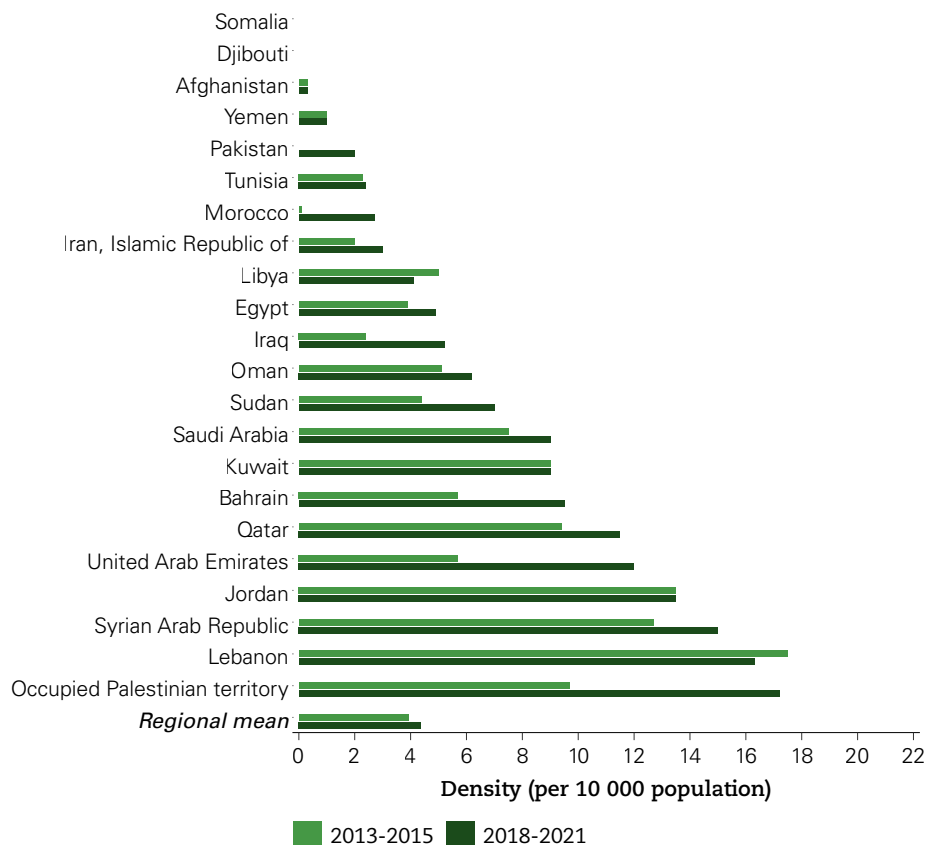
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- Strengthen health workforce at primary care level to ensure competent delivery of the essential public health functions including emergency preparedness and response and address the gaps exposed by the COVID-19 pandemic.
- Reorient and transform health professionals' education to address the skill mix gaps, and competency needs of current and future health workers, informed by community health needs.
- Strengthen retention strategies and improve the monitoring of increasing mobility of health professionals within and outside the Region and strengthen international collaboration among countries on health workforce data, information exchange and enhanced policy dialogue.
- Strengthen the health workforce information base to guide the design, implementation and monitoring of health workforce strategic plans by establishing/strengthening health workforce databases, information and evidence; and ensuring mechanisms to collect, report, analyse and use reliable workforce data.
- Protect and safeguard the health and well-being of the health workforce and ensure health workers are supported to develop the required skills; are provided with the needed resources; have employment security; and enjoy adequate and regular remuneration and safe, healthy and supportive environments that enable them to deliver respectful and quality care to all.

Available guidance/tools

- Framework for action for health workforce development in the Eastern Mediterranean Region 2017–2030; 2018 (<https://apps.who.int/iris/handle/10665/275462>)
- Building resilient health systems to advance universal health coverage and ensure health security in the Eastern Mediterranean Region; 2022 (<https://apps.who.int/iris/handle/10665/366621>)
- Strengthening the nursing workforce to advance

3.c.1 Density of pharmacists per 10 000 population, 2013-2021



universal health coverage in the Eastern Mediterranean Region; 2019 (<https://apps.who.int/iris/handle/10665/371127>)

- Review of medical education in the Eastern Mediterranean Region: challenges, priorities and a framework for action; 2015 (<https://apps.who.int/iris/handle/10665/250489>)
- WHO interim guidance note: health workforce response to the COVID-19 pandemic: April 2020 (<https://apps.who.int/iris/handle/10665/331949>)

### Key references

- Health workforce. WHO Regional Office for the Eastern Mediterranean [website] (<https://www.emro.who.int/entity/health-workforce/index.html>)
- State of the world's nursing 2020: investing in education, jobs and leadership. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/331677>)

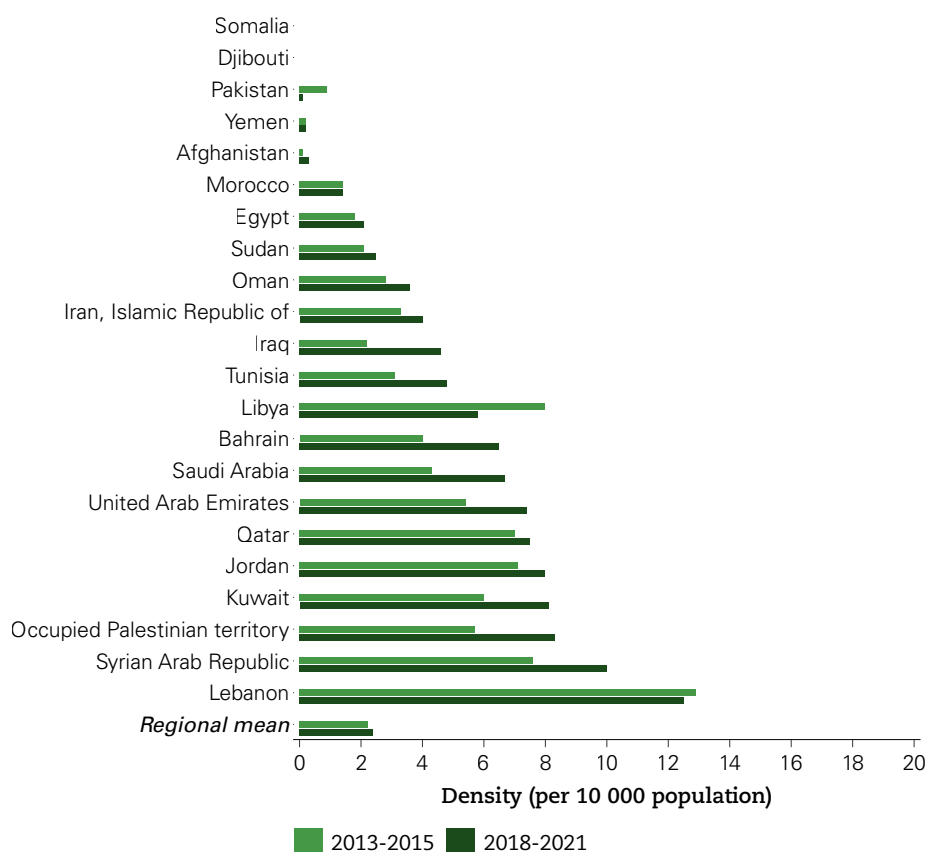
- Eastern Mediterranean Health Observatory. Personnel per 10 000 population - Physicians (<https://rho.emro.who.int/Indicator/TermID/71>)
- Eastern Mediterranean Health Observatory. Personnel per 10 000 population - Nursing and midwifery (<https://rho.emro.who.int/Indicator/TermID/72>)
- Eastern Mediterranean Health Observatory. Personnel per 10 000 population - Dentists (<https://rho.emro.who.int/Indicator/TermID/73>)
- Eastern Mediterranean Health Observatory. Personnel per 10 000 population - Pharmacists (<https://rho.emro.who.int/Indicator/TermID/74>)

**Target 3.d:** Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

### ■ Indicator 3.d.1: International Health

### Data sources

#### 3.c.1 Density of dentists per 10 000 population, 2013-2021



### Regulations (IHR) capacity and health emergency preparedness

#### Current situation

- The International Health Regulations capacity and health emergency preparedness index in the Region in 2021 ranged from 34 in Somalia to 96 in United Arab Emirates, with a regional average of 65.
- In 2021, the IHR capacity and health emergency preparedness index was below 66 in half of the countries of the Region.

#### Key message

- Ensure that National Action Plans for Health Security are reviewed in the context of the COVID-19 pandemic response, updated to enhance health security and the health system and implemented across all sectors.

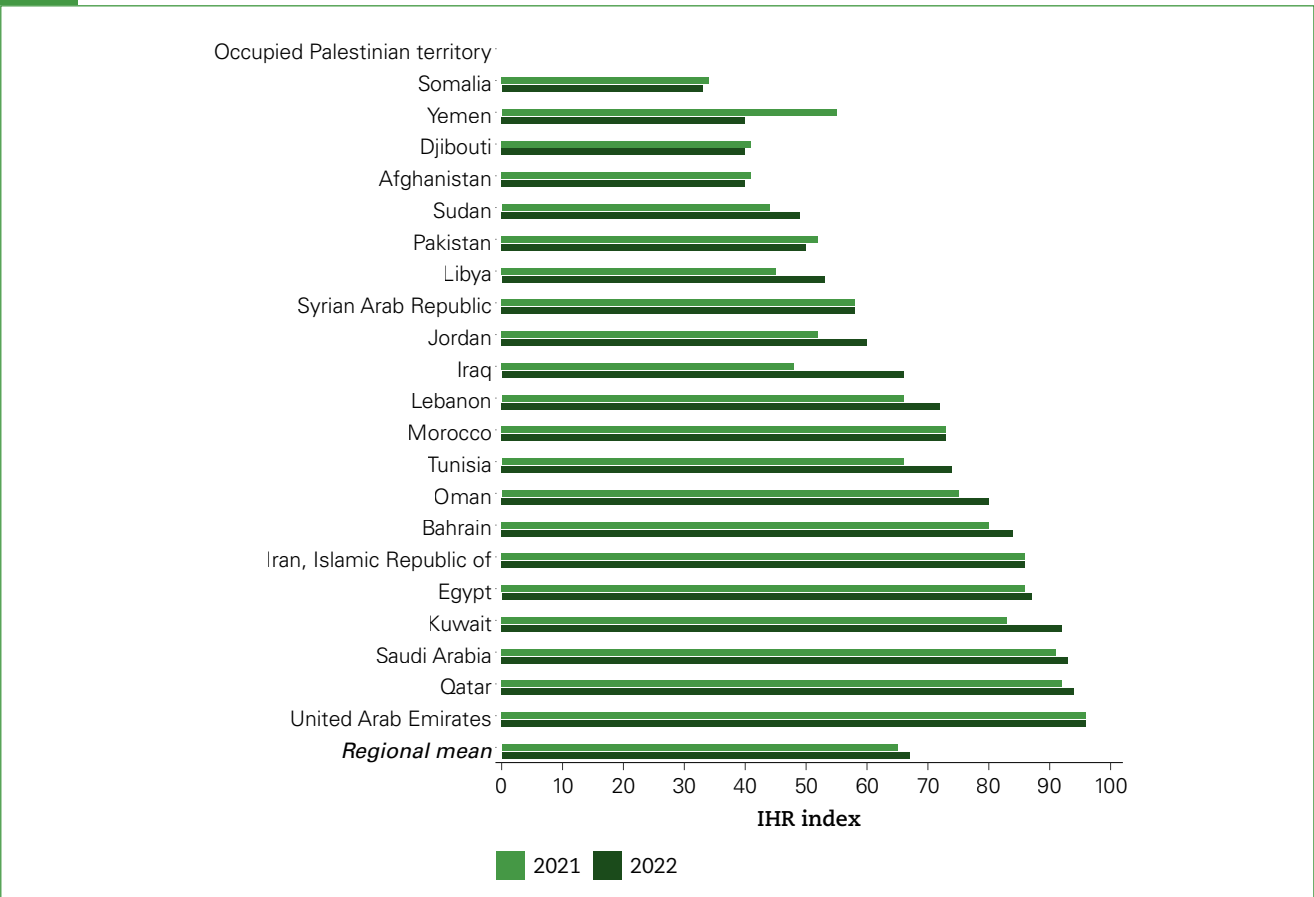
#### Challenges

- Limited awareness of IHR obligations across national sectors. The IHR are often seen as a rigid legal process and not operational in nature, which severely limits the mandate of the IHR National Focal Point.
- Weak national capacities for the surveillance and response functions required to facilitate the timely notification of any event that may constitute a public health emergency of international concern, and to respond to requests for verification of information about these events.
- Difficulties in fostering multisectoral coordination mechanisms and advocacy across all relevant national sectors to ensure that IHR implementation is effective as a national legal obligation and sustaining political commitment to developing the core capacities of IHR (2005).

#### Steps for accelerated action

- Adopt an all-hazards, whole-of-government approach to health threats. Countries should conduct an all-hazards risk assessment and develop their national plans for health security.

#### 3.d.1 IHR index, 2021-2022



- Ensure that public health preparedness and response and disaster risk reduction plans for all hazards are in place, developed and disseminated through a multisectoral approach and based on the identified risk profile.
- Conduct IHR (2005) monitoring and evaluations (simulation exercises, joint external evaluation, state party annual reports, and after/inter-action reviews) regularly to test capacities and plans to ensure that these are adequate and operational.
- Ensure a resourced workforce strategy for IHR implementation across all relevant sectors, including appropriate training.
- Identify competency gaps in the IHR workforce to recalibrate training for the highest priority needs.
- Establish requirements at points of entry to respond to public health emergencies.
- Strategic Partnership for Health Security and Emergency Preparedness (SPH) Portal. Country COVID-19 Intra-action review (IAR) (<https://extranet.who.int/sph/intra-action-review>)
- Strategic Partnership for Health Security and Emergency Preparedness Portal. Joint External Evaluation (JEE) (<https://extranet.who.int/sph/jee>)
- Strategic Partnership for Health Security and Emergency Preparedness Portal. Simulation Exercise (<https://extranet.who.int/sph/simulation-exercise>)

### Key references

- International Health Regulations (2005). Third edition. Geneva: World Health Organization; 2016 (<https://www.who.int/publications/item/9789241580496>)
- Strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005). Seventy-third World Health Assembly. Agenda item 13.2. Resolution WHA73.8. 13 November 2020 ([https://apps.who.int/gb/ebwha/pdf\\_files/WHA73-REC1/A73\\_REC1-en.pdf#page=25](https://apps.who.int/gb/ebwha/pdf_files/WHA73-REC1/A73_REC1-en.pdf#page=25))

### Data sources

- WHO Global Health Observatory. Average of 13 International Health Regulations core capacity scores, SPAR version (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/average-of-13-international-health-regulations-core-capacity-scores-1st-version-of-the-questionnaire>)

### Available guidance/tools

- IHR Monitoring and Evaluation Framework (<https://extranet.who.int/sph/ihr-monitoring-evaluation>)
- NAPHS for all: a country implementation guide for national action plan for health security (NAPHS). WHO: Geneva; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/312220/WHO-WHE-CPI-19.5-eng.pdf?sequence=1#:~:text=A%20National%20Action%20Plan%20for%20Health%20Security%20%28NAPHS%29is,Health%20and%20whole-%20of-government%20approach%20for%20all%20hazards>)
- IHR States Parties self-assessment annual reporting tool. (<https://extranet.who.int/e-spar#:~:text=Electronic%20State%20Parties%20Self-Assessment%20Annual%20Reporting%20Tool%20%28e-SPAR%29,under%20the%20WHO%20IHR%20Monitoring%20and%20Evaluation%20Framework>)

**Indicator 3.d.2: Percentage of bloodstream infections due to selected antimicrobial-resistant organisms<sup>3</sup>**

**Current situation**

**3.d.2: Percentage of bloodstream infections due to *Escherichia coli* caused by *E. coli* resistant to third-generation cephalosporin (ESBL-*E. coli*)**

- In 2020, the mean<sup>4</sup> percentage of all bloodstream infections due to *E. coli* caused by ESBL-*E. coli*

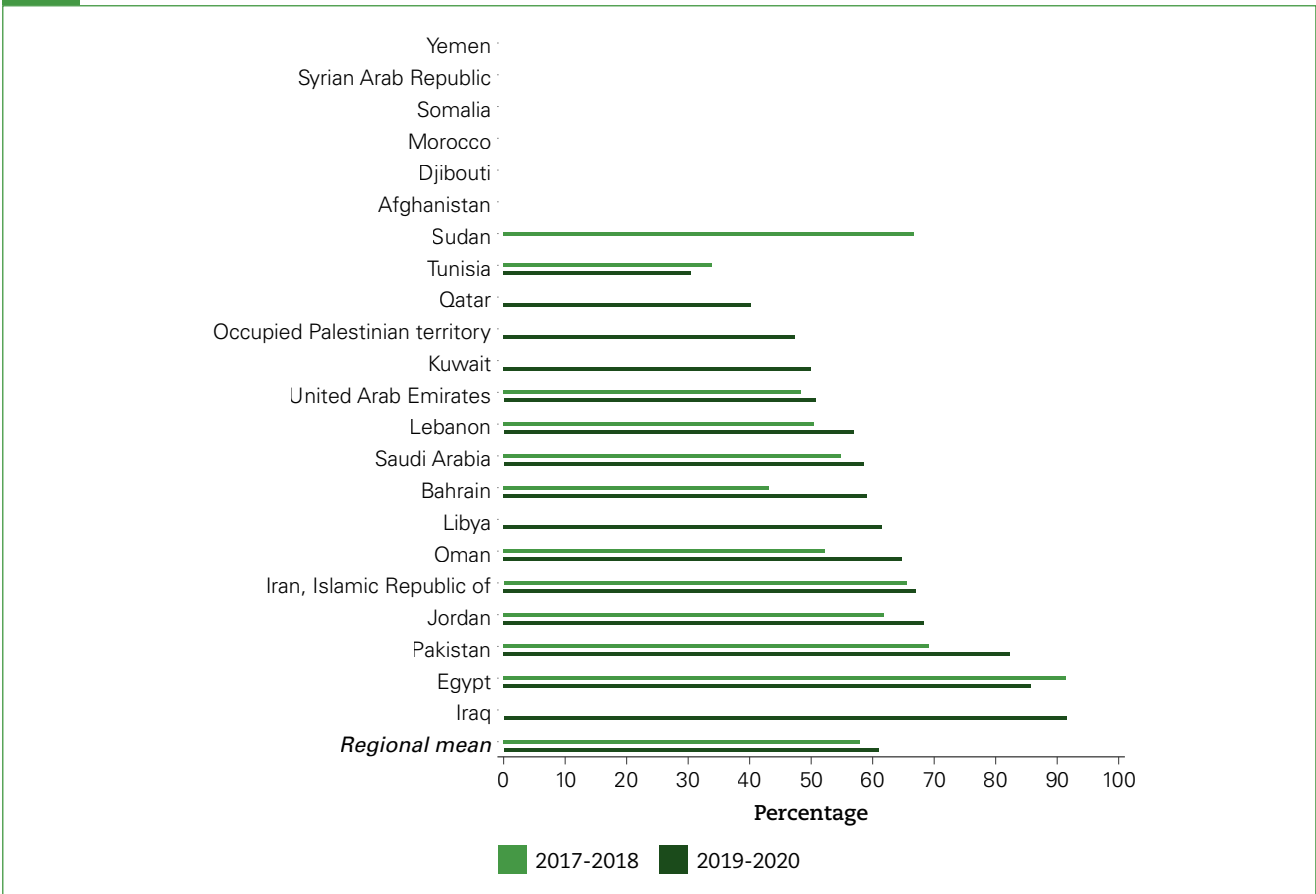
from 15 countries reporting on at least 10 isolates or more was 61%. Values ranged from 30.5% in Tunisia to 91.5% in Iraq.

- The percentage of such infections shows an increasing trend in four out of seven countries with data for both 2017 and 2020.
- In 2017, the mean percentage of such infections reported from seven countries was 58.1%, ranging from 35.9% in Tunisia to 90% in the Islamic Republic of Iran.

<sup>3</sup> *Escherichia coli* (*E. coli*) and *Staphylococcus aureus* (*S. aureus*) are bacteria that cause several acute human infections, both at the community and health care facility levels. *E. coli* is highly prevalent in both humans and animals, and in the environment, and is thus an excellent indicator for monitoring antimicrobial resistance (AMR) across different sectors in line with the AMR One Health approach. *E. coli* resistant to third-generation cephalosporins are largely spread in hospital settings and infections with this type of resistant bacterium leads to the increased use of last-resort antibiotics (carbapenems) against which new types of AMR are emerging. The effective control of *E. coli* resistant to third-generation cephalosporins (ESBL-*E. coli*) and of methicillin-resistant *S. aureus* (MRSA) will ultimately preserve the effectiveness of last-resort antibiotics in treating severe infections.

<sup>4</sup> We used the arithmetic mean instead of the weighted population mean because these estimates are based on number of isolates, not number of patients and some of the larger countries in the Region report few estimates while some of the smaller countries in the Region report on a large number of isolates, thus their data is more reliable.

**3.d.2 Bloodstream infections due to ESBL-E.Coli, 2017-2020**



Note: Values based on less than 10 isolates are not presented as they are unlikely to be representative of the whole country. Here we present the arithmetic mean.

### 3.d.2: Percentage of bloodstream infections due to methicillin-resistant *Staphylococcus aureus*

- In 2020, the mean percentage of all bloodstream infections caused by methicillin-resistant *Staphylococcus aureus* (MRSA) from 17 countries reporting on at least 10 isolates or more was 48%. Values ranged from 0% in Djibouti to 100% in Egypt.
- The percentage of such infections show an increasing trend in seven out of ten countries (Egypt, Islamic Republic of Iran, Jordan, Lebanon, Pakistan, Saudi Arabia and the United Arab Emirates) with data for both 2017 or 2018 and 2020.
- In 2017, the mean percentage of such infections reported from five countries was 39%, ranging from 21.6% in Tunisia to 62.7% in Pakistan.

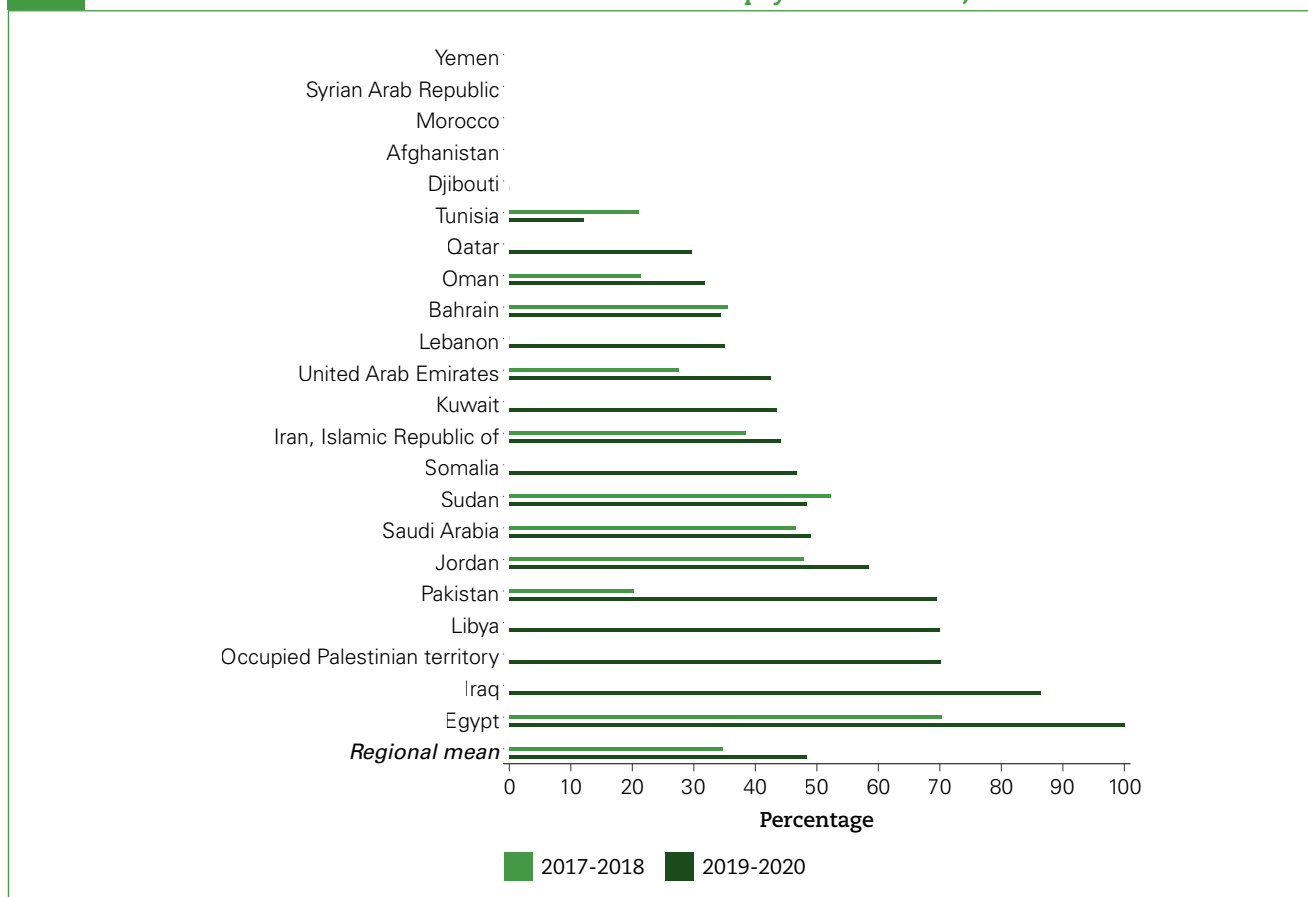
### Key message

- The Region has a high prevalence of bloodstream infections due to both MRSA and ESBL-*E. coli* among the reported isolates. These types of antimicrobial-resistant organisms and infections are also resistant to the last-resort drugs (e.g. vancomycin for MRSA infections and carbapenems for ESBL-*E. coli*), which limits the options for treatment of patients infected with these organisms.

### Challenges

- Limited awareness about antimicrobial resistance (AMR) and infection prevention and control (IPC) across all sectors.
- Lack of buy-in, domestic funding and resource mobilization for AMR and IPC and thus, limited intersectoral collaboration between the human, animal and environmental sectors.

### 3.d.2 Bloodstream infections due to methicillin-resistant *Staphylococcus aureus*, 2017–2020



Note: Values based on less than 10 isolates are not presented as they are unlikely to be representative of the whole country. Here we present the arithmetic mean.

- Very low reported number of isolates from some countries which affects the reliability of percentage of resistance values from these countries.
- Lack of data on these AMR types in some countries.
- Lack of capacities, particularly in low-resource settings, in the fields of epidemiology, surveillance, data management, microbiology, infection prevention and control and infectious disease.
- Underutilization of microbiological diagnostics in clinical practice.
- Insufficient incentives to change actions to conserve antibiotic effectiveness among patients, physicians, hospitals, pharmaceuticals and agricultural sectors.

### Steps for accelerated action

- Enhance advocacy on AMR to ensure political leadership and engagement and to enforce national policies and legislation against AMR.
- Enhance national capacities in the areas of surveillance, microbiology, infection prevention and control, and antimicrobial stewardship.
- Establish national AMR surveillance systems and report good quality AMR data either through a national surveillance system and/or the WHO Global Antimicrobial Resistance Surveillance System (GLASS).
- Strengthen information, education and communications about AMR.
- Establish/strengthen national and facility-level IPC programmes to reduce the spread of resistant organisms in health-care settings.

### Available guidance/tools

- Global Antimicrobial Resistance Surveillance System. Manual for early implementation. WHO; 2015 ([https://apps.who.int/iris/bitstream/handle/10665/188783/9789241549400\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/188783/9789241549400_eng.pdf))
- Global Antimicrobial Resistance Surveillance System (GLASS). Guide to preparing aggregated antimicrobial resistance data files. WHO; 2016 (<https://www.who.int/publications/i/item/WHO-DGO-AMR-2016.6>)
- Global Antimicrobial Resistance Surveillance System (GLASS). Guide to uploading aggregated antimicrobial resistance data. WHO; 2016 (<https://www.who.int/publications-detail-redirect/WHO-DGO-AMR-2016.7>)

[www.who.int/publications-detail-redirect/WHO-DGO-AMR-2016.7](https://www.who.int/publications-detail-redirect/WHO-DGO-AMR-2016.7))

- National antimicrobial resistance surveillance systems and participation in the Global Antimicrobial Resistance Surveillance System (GLASS): a guide to planning, implementation, and monitoring and evaluation. WHO; 2016 (<https://apps.who.int/iris/handle/10665/251554>)
- Interim practical manual supporting national implementation of the WHO Guidelines on core components of infection prevention and control programmes. WHO; 2017 (<https://apps.who.int/iris/bitstream/handle/10665/330073/WHO-HIS-SDS-2017.8-eng.pdf?sequence=1&isAllowed=y>)

### Key references

- Global Antimicrobial Resistance Surveillance System (GLASS) [website] (<https://www.who.int/initiatives/glass>)
- Global Antimicrobial Resistance Surveillance System (GLASS) report. Early implementation 2016–2017. Geneva: World Health Organization; 2018 (<https://www.who.int/publications-detail-redirect/9789241513449>)
- Global Antimicrobial Resistance Surveillance System (GLASS) report. Early implementation 2017–2018. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/rest/bitstreams/1173496/retrieve>)
- Global Antimicrobial Resistance and Use Surveillance System (GLASS) report. Early implementation 2020. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/332081>)
- Global Antimicrobial Resistance and Use Surveillance System (GLASS) Report: 2021. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240027336>)
- Global antimicrobial resistance and use surveillance system (GLASS) report: 2022. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240062702>)

### Data sources

- WHO Global Health Observatory. Indicator 3.d.2: Proportion of bloodstream infections due to selected antimicrobial-resistant organisms (%) (<https://www.who.int/data/gho/indicator-metadata-registry/imr-details/5751>)



## Goal 4

# Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

**Target 4.1:** By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes

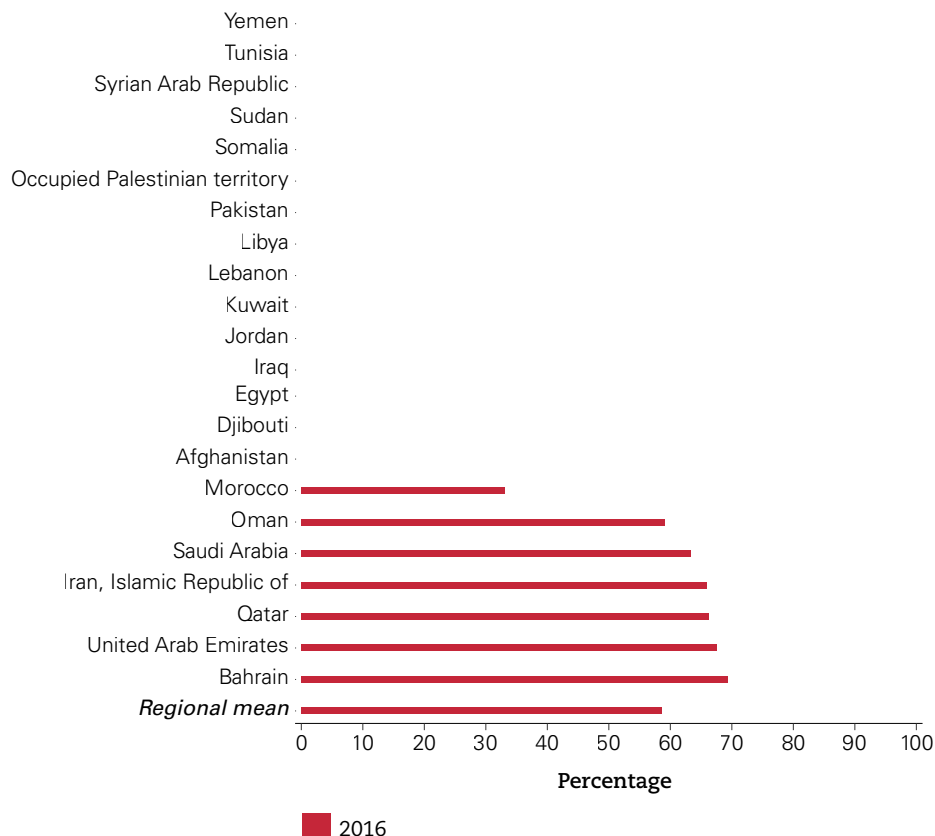
■ **Indicator 4.1.1:** Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex

**4.1.1:** Proportion of children at the end of primary achieving at least a minimum proficiency level in reading

### Current situation

- Data on the proportion of children at the end of primary achieving at least a minimum proficiency level in reading is available only for 2016 from seven countries of the Region.
- In 2016, the proportion of all children at the end of primary achieving at least a minimum proficiency level in reading among the seven countries with reported data in the Region ranged from 33.1% in Morocco to 69.4% in Bahrain.
- Among boys, the proportion at the end of primary achieving at least a minimum proficiency level in reading among six countries with reported data in the Region ranged from 50.1% in Oman to 61.6% in United Arab Emirates.

### 4.1.1 Proportion of children at the end of primary achieving at least a minimum proficiency level in reading, both sexes, 2016



**Goal  
4**

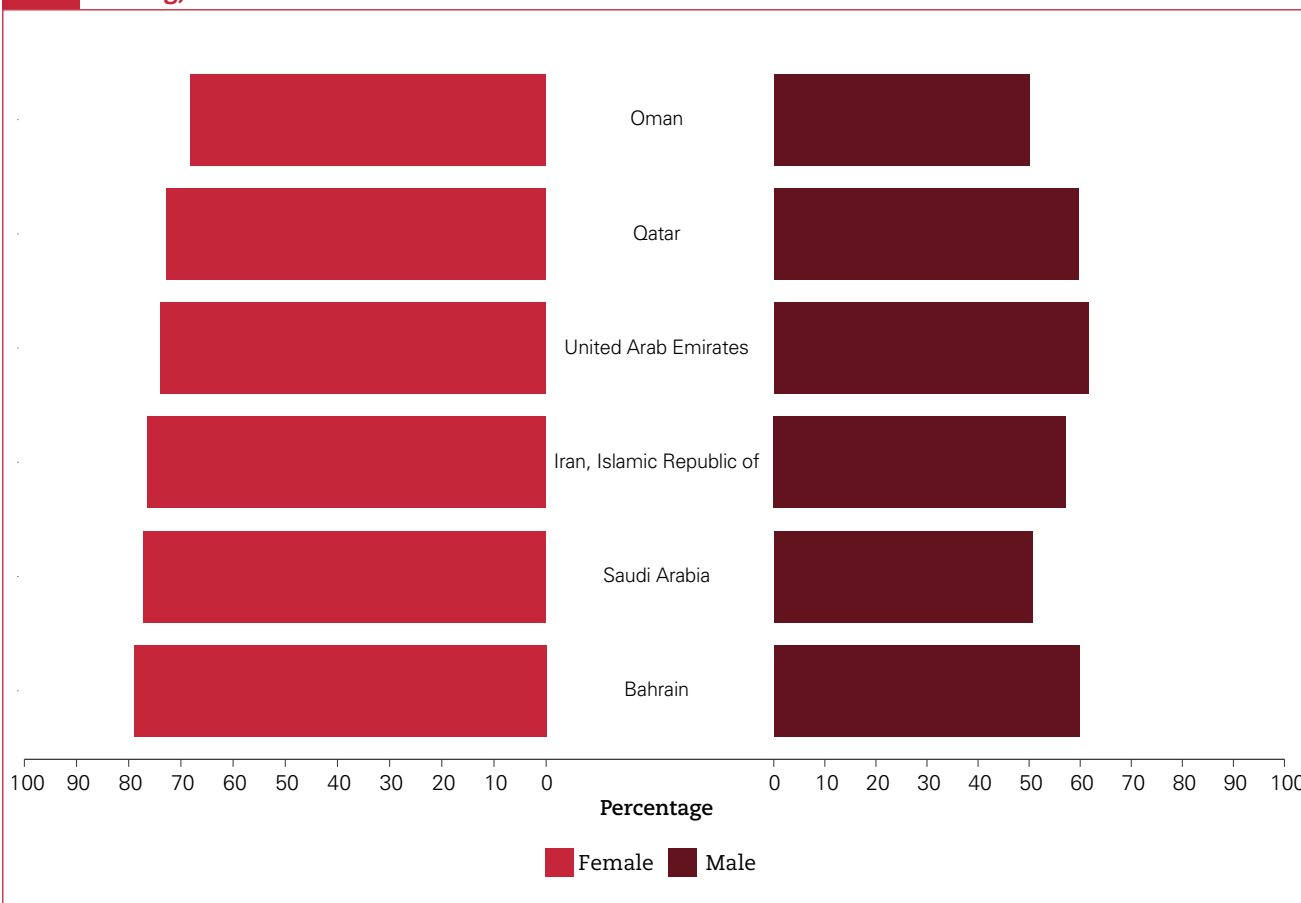
- Among girls, the proportion at the end of primary achieving at least a minimum proficiency level in reading among six countries with reported data in the Region ranged from 68.2% in Oman to 79.0% in United Arab Emirates.
- The proportion of children at the end of primary achieving at least a minimum proficiency level in reading among the six countries with reported data in the Region was consistently higher among girls than boys.
- There were negligible changes in primary education completion rate between 2015 and 2020 in most countries of the Region with reported data.
- The population-weighted mean primary education completion rate in the Region fell slightly from 70.7% in 2015 to 69.4% in 2020.
- In 2020, the primary education completion rate among the eight countries with reported data in the Region ranged from 53.2% in Pakistan to 99.5% in occupied Palestinian territory.
- Among boys, the primary education completion rate among the eight countries with reported data in the Region ranged from 53.7% in Pakistan to 99.5% in occupied Palestinian territory.
- Among girls, the primary education completion rate among the eight countries

**4.1.2: Primary education completion rate**

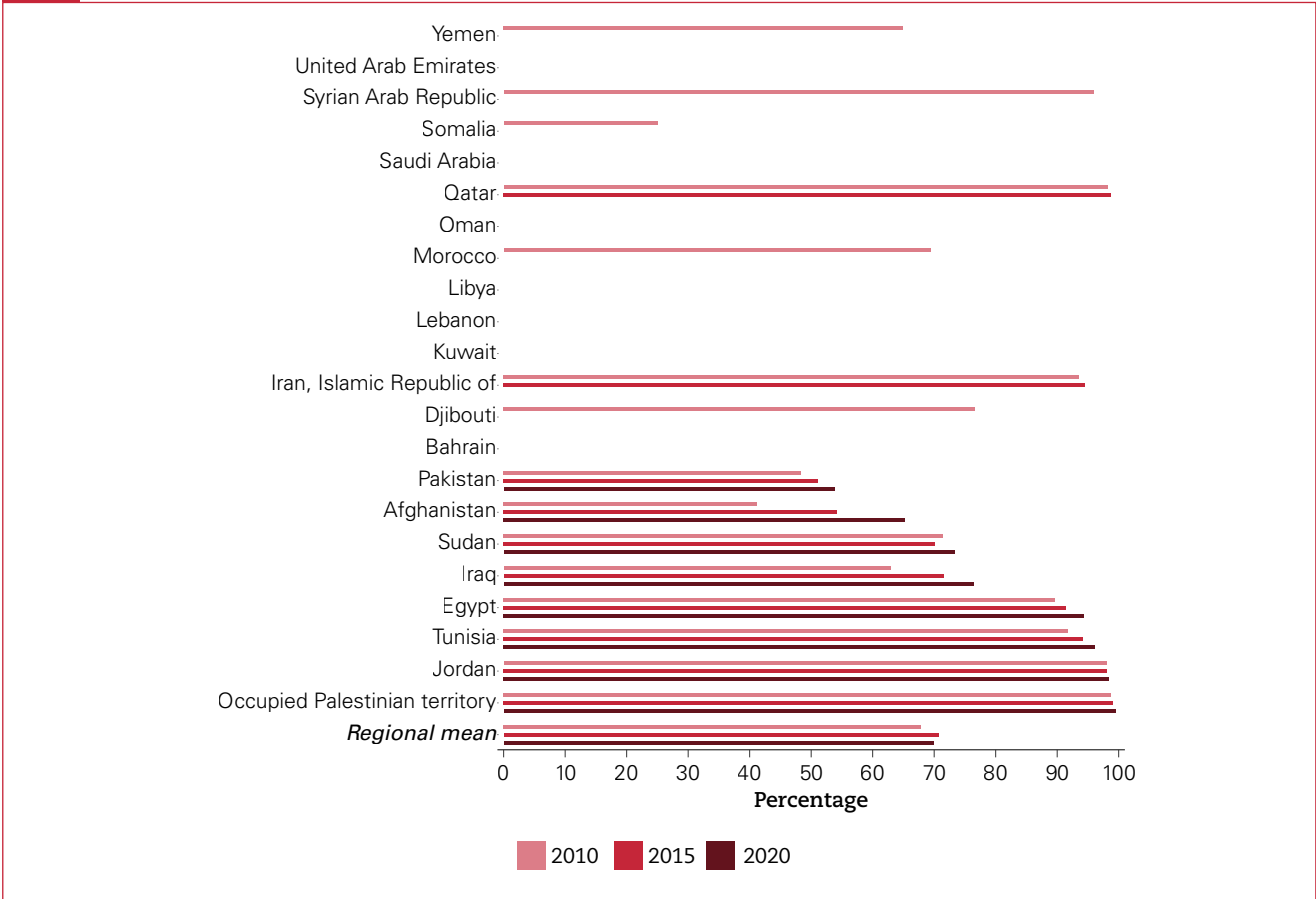
**Current situation**

- Trend data on the primary education completion rate over the period 2010 to 2020 is reported in eight countries of the Region.

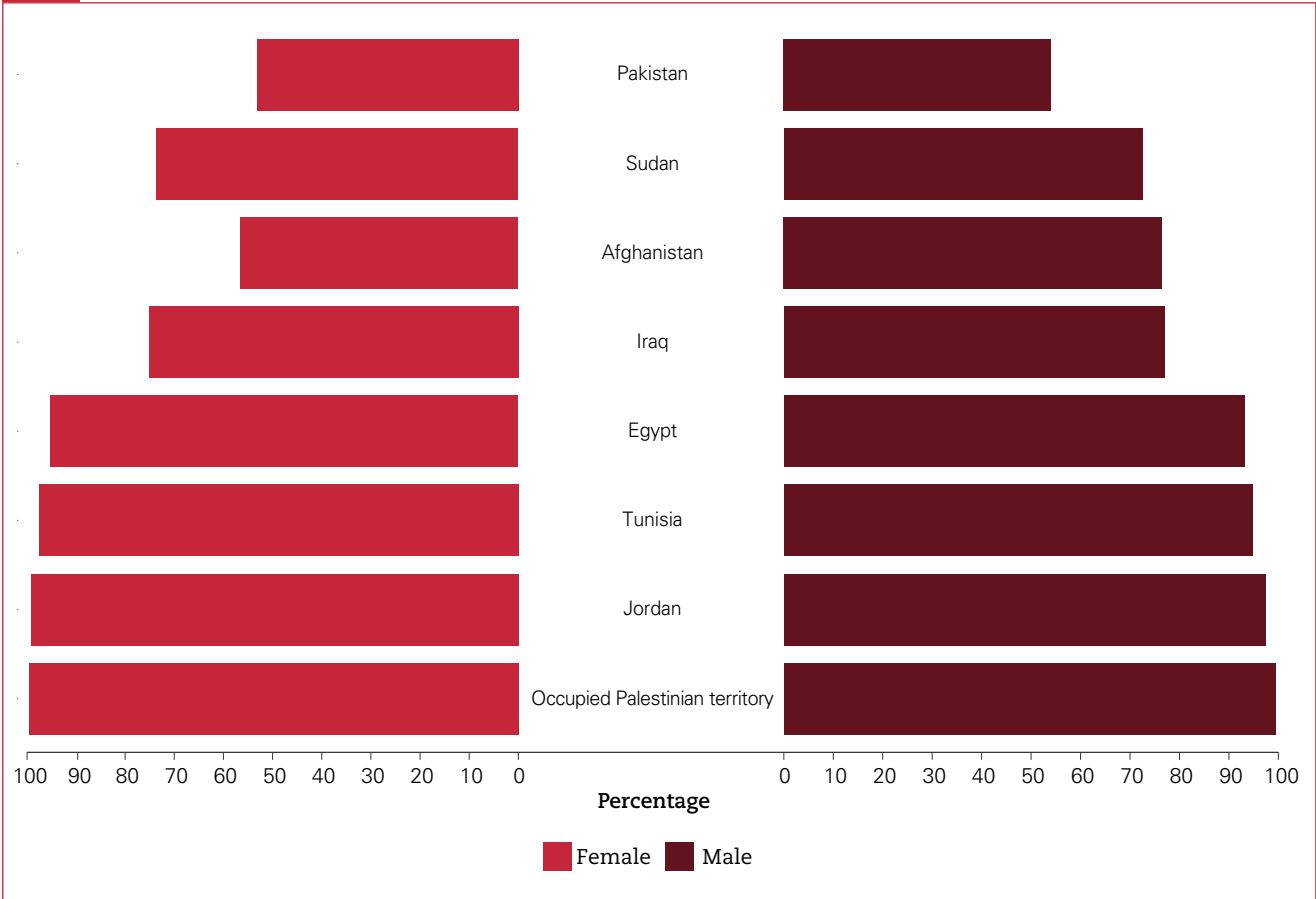
**4.1.1 Proportion of children at the end of primary achieving at least a minimum proficiency level in reading, 2016**



#### 4.1.2 Primary education completion rate, 2010–2020



#### 4.1.2 Primary education completion rate, 2020



## Goal 4

with reported data in the Region ranged from 52.1% in Pakistan to 99.5% in occupied Palestinian territory.

- The primary education completion rate in five of the eight countries with reported data in the Region in 2020 was higher among girls than boys.

### Key message

- Transform education systems to provide children and young people with flexible learning opportunities and to equip them with skills and knowledge beyond traditional literacy and numeracy.

### Challenges

- Conflict and crises leave a significant proportion of children not in school and put others at risk as education facilities are jeopardized by continued instability.
- Poor-quality educational systems are leaving children ill-equipped for the labour market and thus for meaningful and dignified work.

### Steps for accelerated action

- Align curricula, assessment and teacher development systems for relevant learning.
- Promote child-friendly, violence-free learning environments in schools and the community.
- Include child-centred teaching methods and life skills-related content aligned with the requirements of the labour market.
- Implement innovative and technology-enabled interventions to expand access to education and learning throughout the life-cycle.

### Key references

- Education: UNICEF Middle East and North Africa [website] (<https://www.unicef.org/mena/education>)

### Data sources

- UNESCO Institute for Statistics data browser for SDG 4 (<http://sdg4-data.uis.unesco.org/>)

## Goal 5

# Achieve gender equality and empower all women and girls

**Target 5.2:** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

■ **Indicator 5.2.1:** Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age

### Current situation

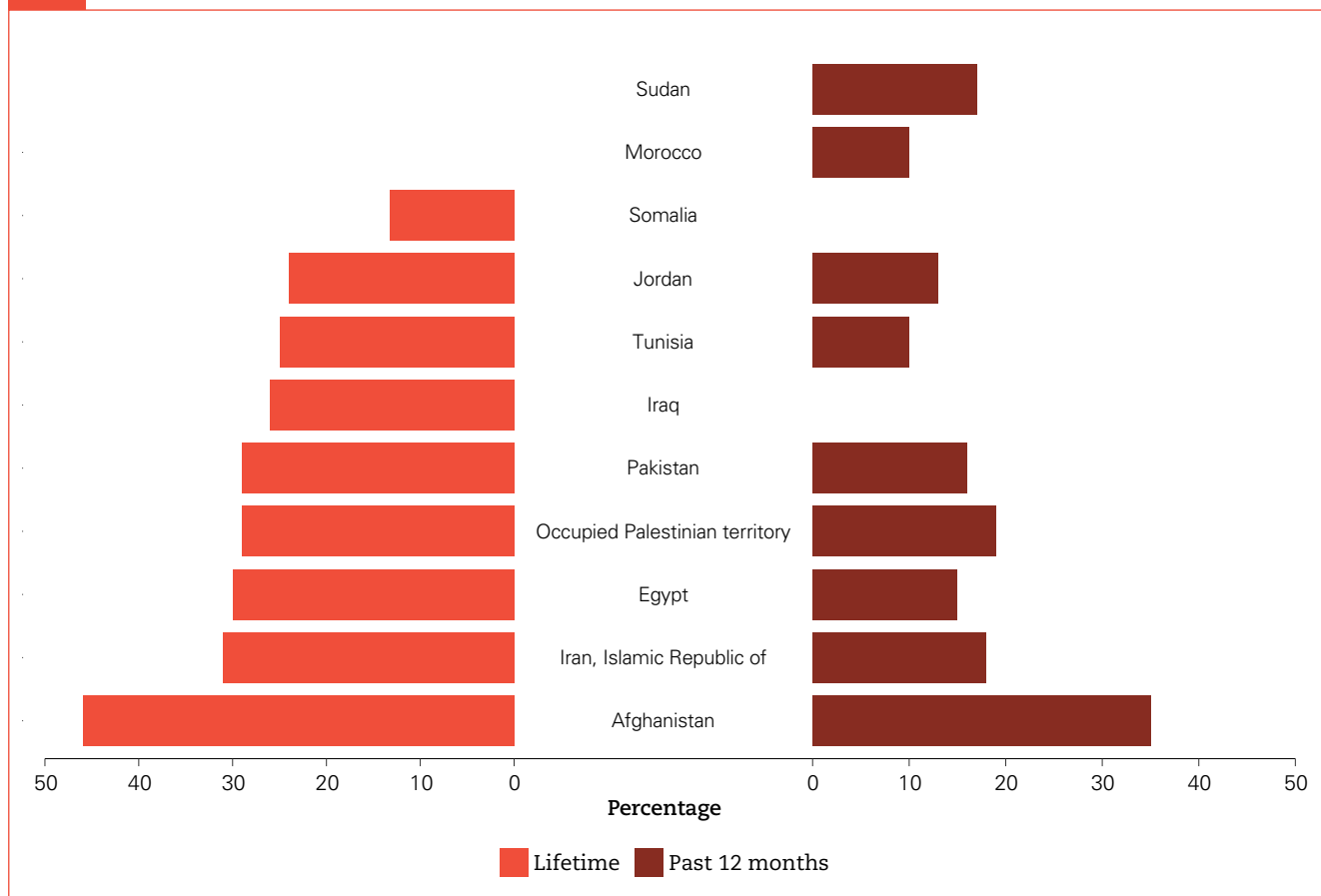
- Based on available data from demographic and health surveys conducted in 2018 and 2020, the proportion of ever-partnered women and girls

aged 15–49 years subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months in nine countries of the Region was highest in Afghanistan (35%) and lowest in Morocco (10%) and Tunisia (10%).

- The proportion of ever-partnered women and girls aged 15–49 years ever subjected to physical, sexual or psychological violence by a current or former intimate partner in their lifetime in nine countries of the Region was highest in Afghanistan (46%) and according to the Somalia National Bureau of Statistics, lowest in Somalia (13.3%).
- Overall, 31% of ever married/partnered women aged 15–49 in the Region have experienced physical and/or sexual violence from a current

5.2.1

### Proportion of ever-partnered women and girls aged 15 years and older subjected to violence, 2015–2019



Note: Data for Afghanistan, Egypt, Islamic Republic of Iran, Jordan, Morocco, occupied Palestinian territory, Pakistan, Somalia, Sudan and Tunisia are from the WHO estimates based on demographic and health surveys. At the time the estimates were generated, the data for Somalia were not yet included. Here we report the data for Somalia as taken from their demographic and health survey.

or former husband or male partner at least once in their lifetime. This represents up to 53 million women.

### Key message

- Strengthen the health sector response as part of a multisectoral response aligned with WHO guidance by addressing risk factors and determinants of interpersonal violence, ensuring equitable access to health-care services and improving the routine collection of data and evidence.

### Challenges

- Violence against women is still deeply rooted in social, political and economic structures and systems, where gender inequalities and discrimination persist and proliferate.
- Lack of reporting, or underreporting, which may lead to inaccurate data collection.
- Lack of reliable, comprehensive and comparable data on various forms of violence against women. Only a subset of countries in the Region have data on this indicator and in some cases only for lifetime exposure, not the past 12 months. Up-to-date data is missing because data is not collected on a regular basis.
- Humanitarian crises and sociopolitical and economic instability in the Region increase the risk of exposure to violence for women and girls and can bring new forms of violence.

### Steps for accelerated action

- Strengthen health system leadership and governance by publicly committing to condemning and addressing all forms of violence against women and girls.
- Strengthen health service delivery and health provider capacity to respond to violence against women and girls.
- Strengthen programming to prevent violence against women and girls.
- Enhance national health information systems and surveillance systems to enable the routine collection of data and evidence on violence against women and girls.

### Available guidance/tools

- Global plan of action to strengthen the role of the health system within a national multisectoral

response to address interpersonal violence, in particular against women and girls, and against children. WHO; 2016 (<https://www.who.int/publications/i/item/9789241511537>)

- Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines. WHO; 2013 (<https://www.who.int/publications/i/item/9789241548595>)
- Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. WHO; 2017 (<https://www.who.int/publications/i/item/9789241513005>)
- Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. WHO; 2014 (<https://www.who.int/publications/i/item/WHO-RHR-14.26>)
- Clinical management of rape and intimate partner violence survivors. Developing protocols for use in humanitarian settings. WHO; 2020 (<https://www.who.int/publications/i/item/9789240001411>)

### Key references

- The DHS Program Demographic and Health Surveys. USAID [online database] (<https://dhsprogram.com/>)
- Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341337>)
- Somalia National Bureau of Statistics, Federal Government of Somalia. The Somali Health and Demographic Survey 2020.

### Data sources

- Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341337>)
- Somalia National Bureau of Statistics, Federal Government of Somalia. The Somali Health and Demographic Survey 2020.

**Target 5.6:** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

**Indicator 5.6.1: Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care**

**Current situation**

- Data on the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care are lacking in the Eastern Mediterranean Region and are only available for two countries of the Region.

- In 2018, the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care was 31.5% in Pakistan and 58.2% in Jordan.

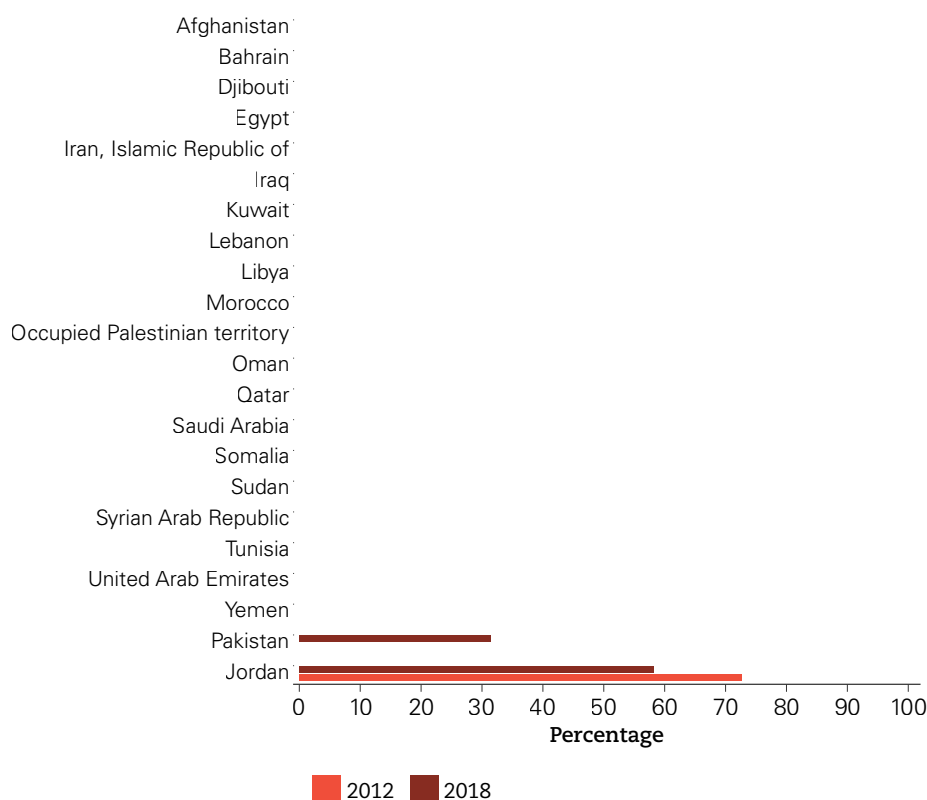
**Key message**

- Strengthen health information systems to routinely collect data on this important indicator to guide actions aimed at scaling up and improving access to and the acceptability of sexual and reproductive health (SRH) services.

**Challenges**

- Gender inequalities and discrimination persist and are proliferating, thus hampering the ability of woman to make decisions on their own health.
- Limited access, affordability and acceptability of SRH services.
- Lack of access to quality information on SRH.
- Traditional beliefs, myths and misconceptions are negatively influencing decision-making on SRH.

**5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care; 2012 and 2018**



- There is a missed opportunity to include questions on informed decisions in household surveys. The relevant modules are available but rarely included in the administered questionnaires.

### Steps for accelerated action

- Remove unnecessary legal, medical, clinical and regulatory barriers hampering access to sexual and reproductive health services.
- Empower women to ensure their autonomy in decision-making on their own health through conducive regulatory frameworks, educational and occupational opportunities, exposure to media and women-centred economic incentives.
- Scale up and improve access to – and acceptability of – quality SRH services by training service providers on quality of care and provision of contraception and other essential SRH supplies to leave no one behind.
- Improve educational opportunities for girls.
- Increase the availability and accessibility of information on SRH and challenge misconceptions.
- Include information on reproductive health in the school curriculum and the media.
- Questions to estimate indicator 5.6.1 should be included in all Member States' population-based survey modules such as the Demographic and Health Survey and the Multiple Indicator Cluster Survey.
- Collect data on SDG indicator 5.6.1 through the new wave of Multiple Indicator Cluster Surveys (MICS) which is under way (MICS7) and request countries to make further efforts to collect regular data on this important SDG indicator.

### Available guidance/tools

- Quality of care in contraceptive information and services, based on human rights standards: a checklist for health care providers. WHO; 2017 (<https://apps.who.int/iris/handle/10665/254826>)
- Women's ability to decide. Issue Brief on Indicator 5.6.1 of the Sustainable Development Goals. United Nations Population Fund. 2020 (<https://www.unfpa.org/resources/womens-ability-decide-issue-brief-indicator-561-sustainable-development-goals>)
- Tracking women's decision-making for sexual and reproductive health and reproductive rights. United Nations Population Fund. 2020 (<https://www.unfpa.org/resources/tracking-womens-decision-making-sexual-and-reproductive-health-and-reproductive-rights>)

### Data sources

- Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (SDG 5.6.1). Maternal, newborn, child and adolescent health and ageing [WHO data portal] ([https://www.who.int/data/indicator-explorer-new/mca/proportion-of-women-aged-15-49-who-make-their-own-informed-decisions-regarding-sexual-relations-contraceptive-use-and-reproductive-health-care-\(sdg-5.6.1\)](https://www.who.int/data/indicator-explorer-new/mca/proportion-of-women-aged-15-49-who-make-their-own-informed-decisions-regarding-sexual-relations-contraceptive-use-and-reproductive-health-care-(sdg-5.6.1)))
- National Institute of Population Studies (NIPS) [Pakistan] and ICF. 2019. Pakistan Demographic and Health Survey 2017-18. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF (<https://pwd.punjab.gov.pk/system/files/key%20indicator%20PDSH.pdf>) Department of Statistics (DOS) and ICF. 2019. Jordan Population and Family and Health Survey 2017-18. Amman, Jordan, and Rockville, Maryland, USA: DOS and ICF (<https://dhsprogram.com/pubs/pdf/FR346/FR346.pdf>)



# Goal 6

## Ensure availability and sustainable management of water and sanitation for all

**Target 6.1:** By 2030, achieve universal and equitable access to safe and affordable drinking-water for all

**Indicator 6.1.1:** Proportion of population using safely managed drinking-water services

### Current situation

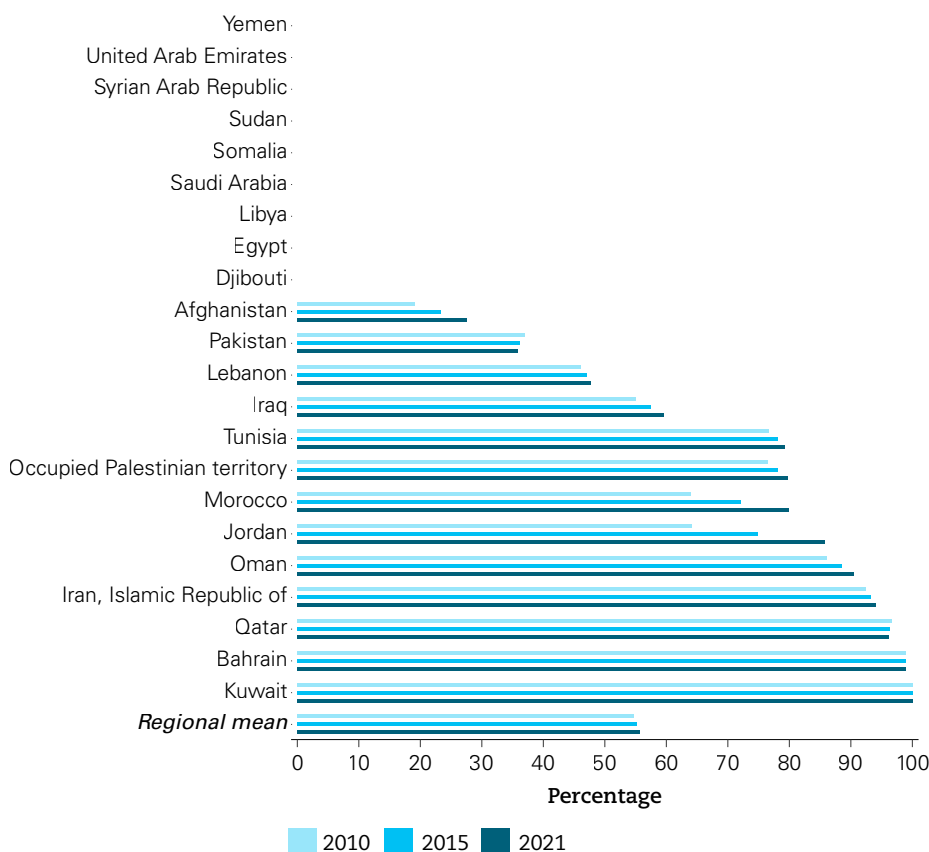
- 55.7% of people in the Region have access to safely managed drinking-water services, leaving more than 324 million people behind.
- There is great variability in the proportion of the population using safely managed drinking-water services and the trend across the Region.
- Data available from 13 countries of the Region show that the proportion of the population using safely managed drinking-water services was persistently low in Afghanistan and highest in Kuwait over the period 2010–2020.

- Between 2010 and 2021, a marked increase of more than 15 percentage points in the proportion of population using safely managed drinking-water services was observed in Jordan and Morocco.
- In 2021, the proportion of the population using safely managed drinking-water services in the Region ranged from 27.6% in Afghanistan to 100% in Kuwait.
- In 2021, the proportion of the population using safely managed drinking-water services in the Region was at least 90% in Oman, Islamic Republic of Iran, Qatar, Bahrain and Kuwait. However, it was less than 50% in Afghanistan, Pakistan and Lebanon.

### Key message

- Develop and implement a multisectoral programme to end open defecation, promote use of innovative technologies to improve and expand safe drinking-water and sanitation services,

### 6.1.1 Population using safely managed drinking-water services, 2010–2021



strengthen the regulatory framework and increase resource allocation.

### Challenges

- Water scarcity, climate change, expanding urbanization, infrastructural interventions which modify the natural environment (e.g. dams), conflict and other crises are key challenges facing the Region.
- Inadequate coverage of safely managed drinking-water services – in 2020, 11% of the population in the Eastern Mediterranean (77 million people) remained without access to even basic water services. Of these, 68 million people live in five countries (Pakistan 22 million, Sudan 17 million, Afghanistan 10 million, Yemen 12 million and Somalia 7 million).
- While access to at least basic services is similar to the global average of 90%, access to safely managed services is 56%, well below the global average of 74%.
- In health-care facilities, only 73% have access to basic water services, leaving more than 198 million people behind.
- Lack of obtainable data on safely managed services due to inaccessibility of data and/or the likely insufficient monitoring of service quality.
- Weak public health sector engagement in their role of regulating and monitoring water and sanitation services.
- Insufficient financial resources to implement WASH plans to meet national targets, and weak regulatory oversight of WASH service delivery.

### Steps for accelerated action

- Implement investment packages to address the needs of the 77 million people who still lack access to basic services drinking-water services as a top priority.
- Implement integrated drinking-water safety management systems encompassing regulation, operational procedures and efficient monitoring and surveillance of service quality.
- Strengthen multisectoral approaches to promote universal safely managed water and sanitation services using innovative technologies to address the challenges such as climate change and water scarcity.
- Scale up investment in WASH service delivery, including in areas with a high burden of disease, and/or ensure links between WASH programmes and programmes aiming to reduce adverse health

outcomes (for example, AMR, cholera, sepsis, and maternal mortality/preventable newborn death).

- Conduct joint sector reviews to guide strategic decisions on resource allocation and extend coverage to those who are unserved and upgrade existing services.
- The health sector should engage and coordinate with WASH actors to align, prioritize and jointly monitor key indicators at national and subnational levels.
- Ensure health-care facilities have and sustain adequate WASH services and share health surveillance data with WASH actors to inform WASH service delivery.

### Available guidance/tools

- Guidelines for drinking-water quality: Fourth edition incorporating the first and second addenda. WHO; 2022 (<https://www.who.int/publications/i/item/9789240045064>)
- Developing drinking-water quality regulations and standards. General guidance with a special focus on countries with limited resources. WHO; 2018 (<https://www.who.int/publications/i/item/9789241513944>)
- Water safety planning: A roadmap to supporting resources (<https://www.who.int/publications/m/item/water-safety-planning-a-roadmap-to-supporting-resources>)
- Water, sanitation, hygiene and health: a primer for health professionals. WHO; 2019 (<https://www.who.int/publications/i/item/WHO-CED-PHE-WSH-19.149>)

### Key references

- Progress on household drinking water, sanitation and hygiene 2000–2020: five years into the SDGs. Geneva: WHO and UNICEF; 2021 (<https://washdata.org/reports/jmp-2021-wash-households>)
- Progress on WASH in health care facilities 2000–2021: special focus on WASH and infection prevention and control (IPC). WHO and UNICEF; 2022 (<https://washdata.org/reports/jmp-2022-wash-hcf>)
- WHO/UNICEF Joint Monitoring Programme [online database] ([www.washdata.org](http://www.washdata.org))

### Data sources

- WHO Global Health Observatory. Population using safely managed drinking-water services (%) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-using-safely-managed-drinking-water-services\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-using-safely-managed-drinking-water-services(-)))

**Target 6.2:** By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations

■ **Indicator 6.2.1: Proportion of population using: (a) safely managed sanitation services; and (b) a hand-washing facility with soap and water**

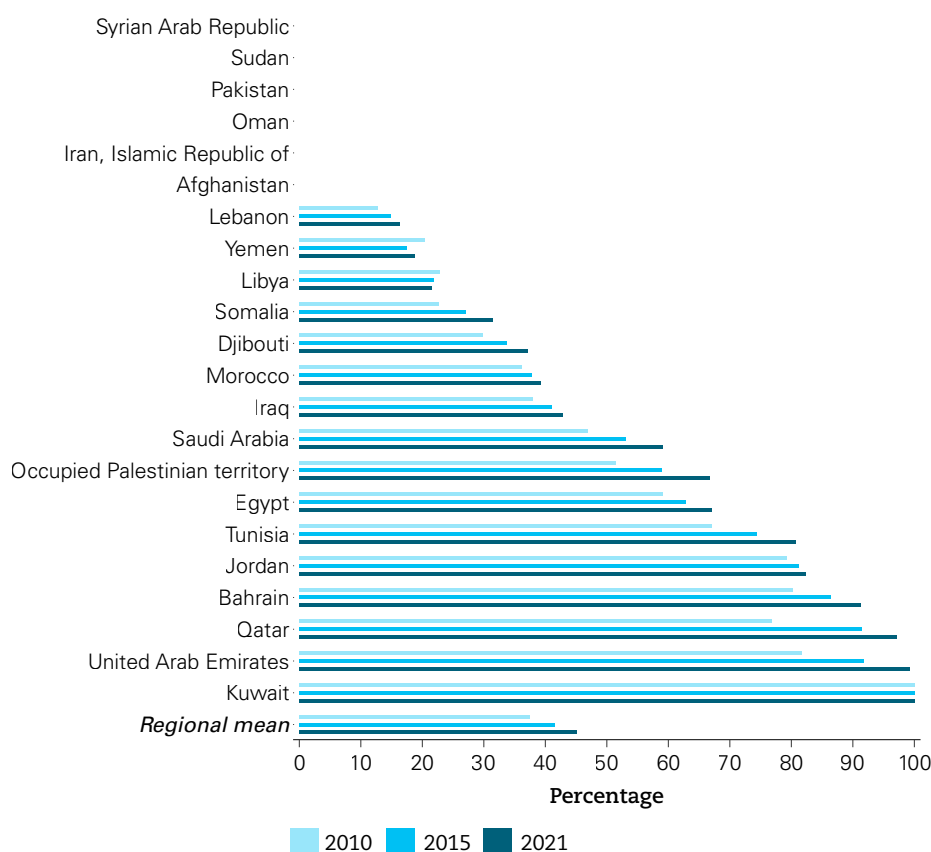
**Current situation**

- Only 45% of the urban population in the Region have access to safely managed sanitation services.
- There is great variability in the proportion of the population using safely managed sanitation services and the trend across the Region.
- Data available from 16 countries of the Region show that the proportion of the population using safely

managed sanitation services was persistently low in Lebanon and highest in Kuwait and the United Arab Emirates over the period 2010–2021.

- Between 2010 and 2021, a marked increase of more than 15 percentage points in the proportion of population using safely managed sanitation services was observed in occupied Palestinian territory and the United Arab Emirates.
- In 2021, the proportion of the population using safely managed sanitation services in the Region ranged from 16.3% in Lebanon to 100% in Kuwait.
- In 2021, the proportion of the population using safely managed sanitation services in the Region was at least 90% in Bahrain, Qatar, United Arab Emirates and Kuwait. However, it was less than 50% in seven countries ranging from 16.3% in Lebanon to 42.9% in Iraq.
- In 2021, 81.5% of the population in the Region had access to basic hygiene services (i.e. a hand-washing facility with soap and water). However, 135 million people still lack basic hygiene services mainly in Pakistan, Sudan, Afghanistan, Somalia and Egypt.

**6.2.1 Proportion of population using safely managed sanitation services, 2010–2021**



## Goal 6

- Only 10 countries reported on hygiene services.
- In 2020, the proportion of the population using basic hygiene services in countries of the Region ranged from 12.5% in Sudan to 97.4% in Oman.

### Key message

- Develop and implement a multisectoral programme to end open defecation, promote use of innovative technologies to improve and expand basic sanitation services, strengthen the regulatory framework and increase resource allocation.

### Challenges

- Open defecation is still practised by 12% of the rural population in the Region (41.9 million people) and basic sanitation services still need to be extended to 21.8% of the Region's population (159.3 million people).
- Persistence of rural-urban inequalities, with open defecation practised by 41.9 million people living in rural areas compared to 0.51 million people living in urban areas, while 121.8 million rural residents lack basic sanitation services compared to 37.6 million urban residents.
- Inadequate coverage of safely managed sanitation services: in the 16 countries for which it was possible to estimate safely managed sanitation services, only 54.3% had access to such services.
- Lack of data on safely managed services due to data inaccessibility and/or the likely insufficient monitoring of service quality.
- Weak public health sector engagement in their role of regulating and monitoring water and sanitation services.
- Insufficient financial resources to implement WASH plans to meet national targets, and weak regulatory oversight of WASH service delivery.

### Steps for accelerated action

- Develop and implement national programmes to accelerate the extension of basic sanitation services to the unserved and to end open defecation.
- Establish and implement a national policy and investment package to raise the level of sanitation services from basic to safely managed.
- Strengthen multisectoral approaches to promote universal safely managed water and sanitation services using innovative technologies to address challenges including climate change and water scarcity.

- Scale up investment in WASH service delivery, including in areas with a high burden of disease, and/or ensure links between WASH programmes and programmes aiming to reduce adverse health outcomes (for example, AMR, cholera, sepsis, and maternal mortality/preventable newborn death).
- Conduct joint sector reviews to guide strategic decisions on resource allocation, extend coverage to those who are unserved and upgrade existing services.
- The health sector should engage and coordinate with WASH actors to align, prioritize and jointly monitor key indicators at national and subnational levels.
- Ensure health-care facilities have (and sustain) adequate WASH services and share health surveillance data with WASH actors to inform WASH service delivery.

### Available guidance/tools

- State of the world's sanitation: An urgent call to transform sanitation for better health, environments, economies and societies. WHO and UNICEF; 2021 (<https://www.who.int/publications/i/item/9789240014473>)
- Guidelines on sanitation and health. WHO; 2018 [website] (<https://www.who.int/publications/i/item/9789241514705>)
- Sanitation safety planning - Second edition. WHO; 2022 (<https://www.who.int/publications/i/item/9789240062887>)
- State of the world's hand hygiene: A global call to action to make hand hygiene a priority in policy and practice. UNICEF and WHO; 2021 (<https://www.who.int/publications/i/item/9789240036444>)

### Key references

- Progress on household drinking water, sanitation and hygiene 2000-2020: five years into the SDGs. Geneva: WHO and UNICEF; 2021 (<https://data.unicef.org/resources/progress-on-household-drinking-water-sanitation-and-hygiene-2000-2020/>)
- WHO/UNICEF Joint Monitoring Programme [online database] ([www.washdata.org](http://www.washdata.org))

### Data sources

- WHO Global Health Observatory. Population using safely managed sanitation services (<https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/population-using-safely-managed-sanitation-services>)

# Goal 8

## Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

**Target 8.5:** By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value

■ **Indicator 8.5.2: Unemployment rate, by sex, age and persons with disabilities**

### Current situation

- There were negligible changes in the unemployment rate for both sexes between 2010 and 2021 in most countries of the Region with available estimates.
- The population weighted mean for unemployment rate for both sexes in all of the countries of the Region with estimates increased slightly from 7.8% in 2012 to 8.3% in 2021.
- In 2021, the unemployment rate for both sexes ranged from 0.14% in Qatar to 26.39% in the

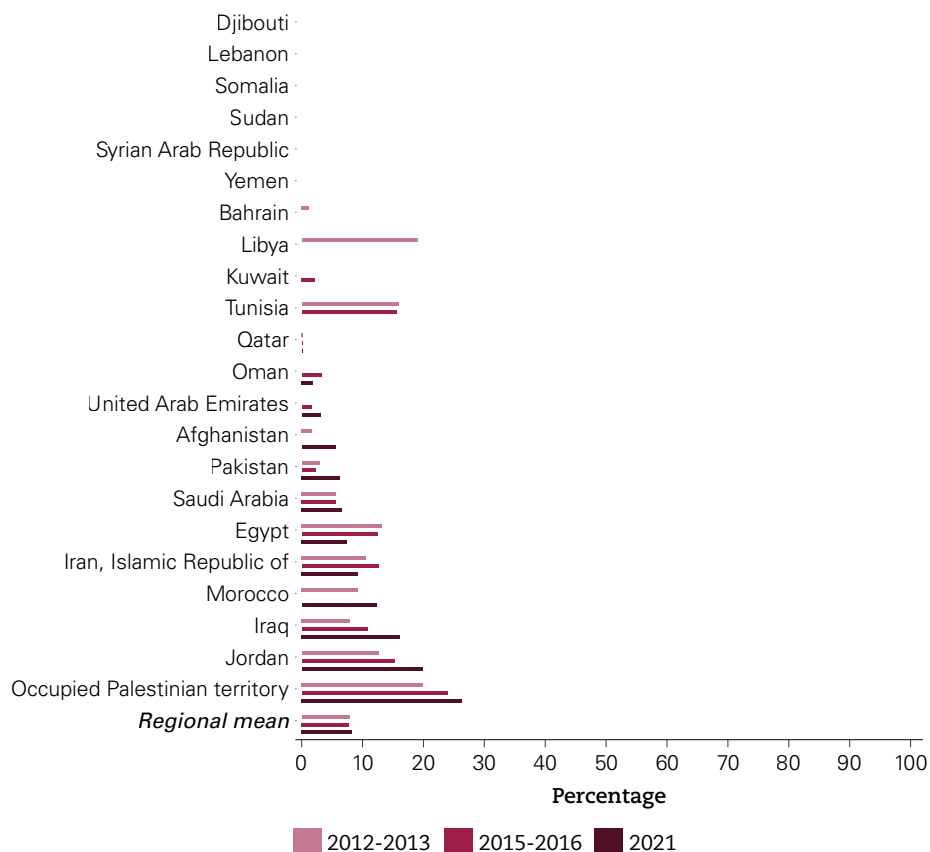
occupied Palestinian territory.

- The population weighted mean for unemployment rate for males in all of the countries of the Region with estimates increased slightly from 6.8% in 2012 to 7.0% in 2021.
- The population weighted mean for unemployment rate for females in all of the countries of the Region with estimates increased slightly from 12.1% in 2012 to 13.9% in 2021.
- In 2021, the unemployment rate for males ranged from 0.1% in Qatar to 22.4% in the occupied Palestinian territory; whereas for females it ranged from 0.5% in Qatar to 42.9% in the occupied Palestinian territory.
- In 2021, the unemployment rate was higher for females than males in all of the countries of the Region with estimates except Afghanistan.

### Key message

- Develop labour market programmes that create formal employment opportunities with a particular

### 8.5.2. Unemployment rate, both sexes, 2012–2021



focus on the engagement of young people and women in the labour market.

### Challenges

- The Region has one of the highest rates of youth unemployment and the lowest women’s labour force participation rate worldwide.
- Sociocultural norms and lack of childcare facilities and safe transport restrict women’s access to work, while unequal wages, restrictive laws and lack of social protection also hinder gender equality within the workforce.
- Climate change, conflicts and displacement, and political instability adversely affect the economic outlook of the Region, including youth employment.

### Steps for accelerated action

- Develop labour market programmes that create formal employment opportunities with a particular focus on the engagement of young people and women in the labour market.

- Improve the collection of data on employment and unemployment disaggregated by sex and age, with a specific focus on vulnerable populations (such as people living with disabilities, migrant workers, refugees, and internally displaced persons).
- Introduce legislation to address minimum wage and equal pay.

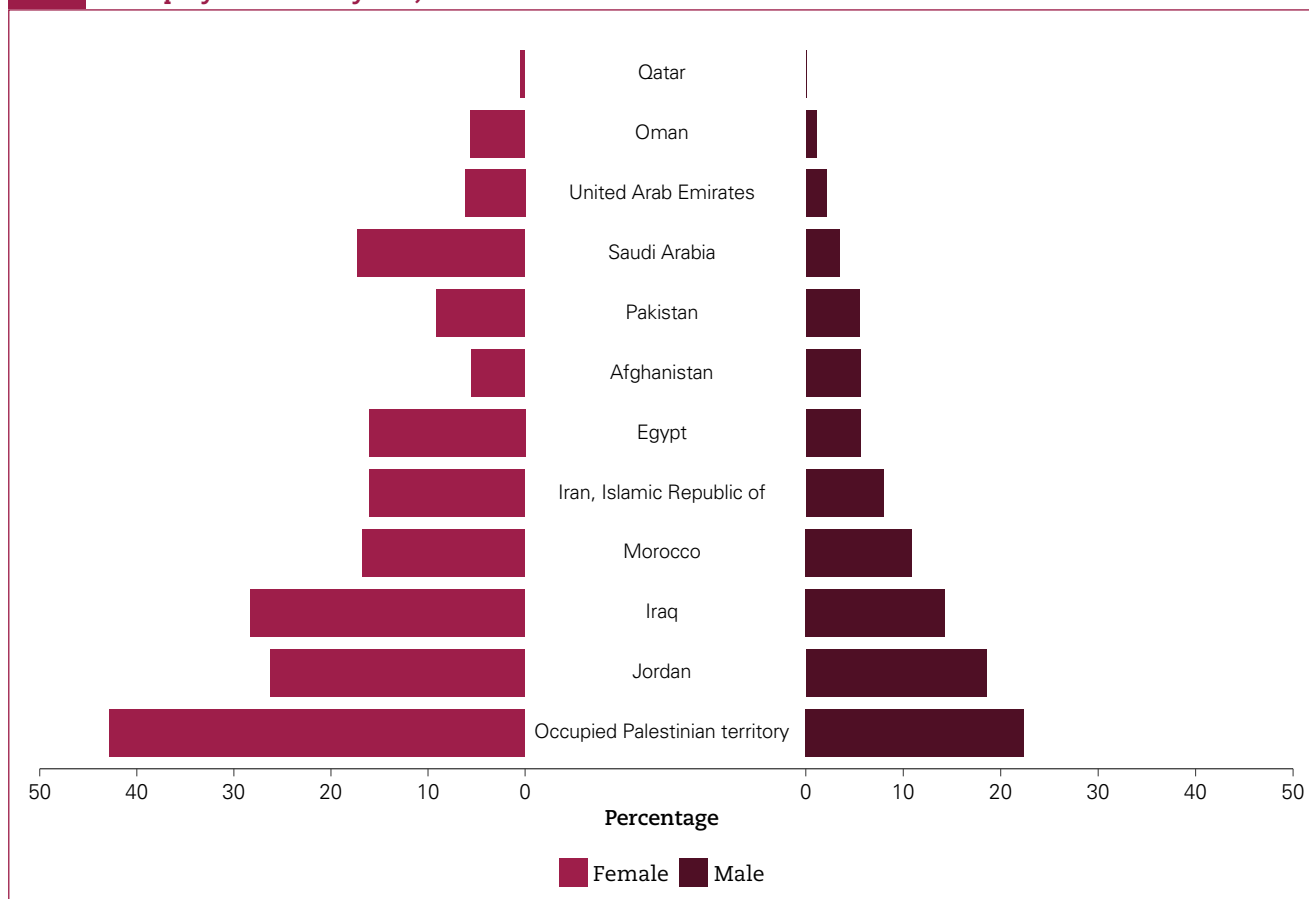
### Key references

- Situational analysis of women and girls in the MENA and Arab States Region. UN Women; 2021 (<https://arabstates.unwomen.org/en/digital-library/publications/2021/11/situational-analysis-of-women-and-girls-in-the-mena-and-arab-states-region>)
- Global employment trends for youth 2022: The Arab states. International Labour Organization; ([https://www.ilo.org/wcmsp5/groups/public/—ed\\_emp/documents/briefingnote/wcms\\_853324.pdf](https://www.ilo.org/wcmsp5/groups/public/—ed_emp/documents/briefingnote/wcms_853324.pdf))

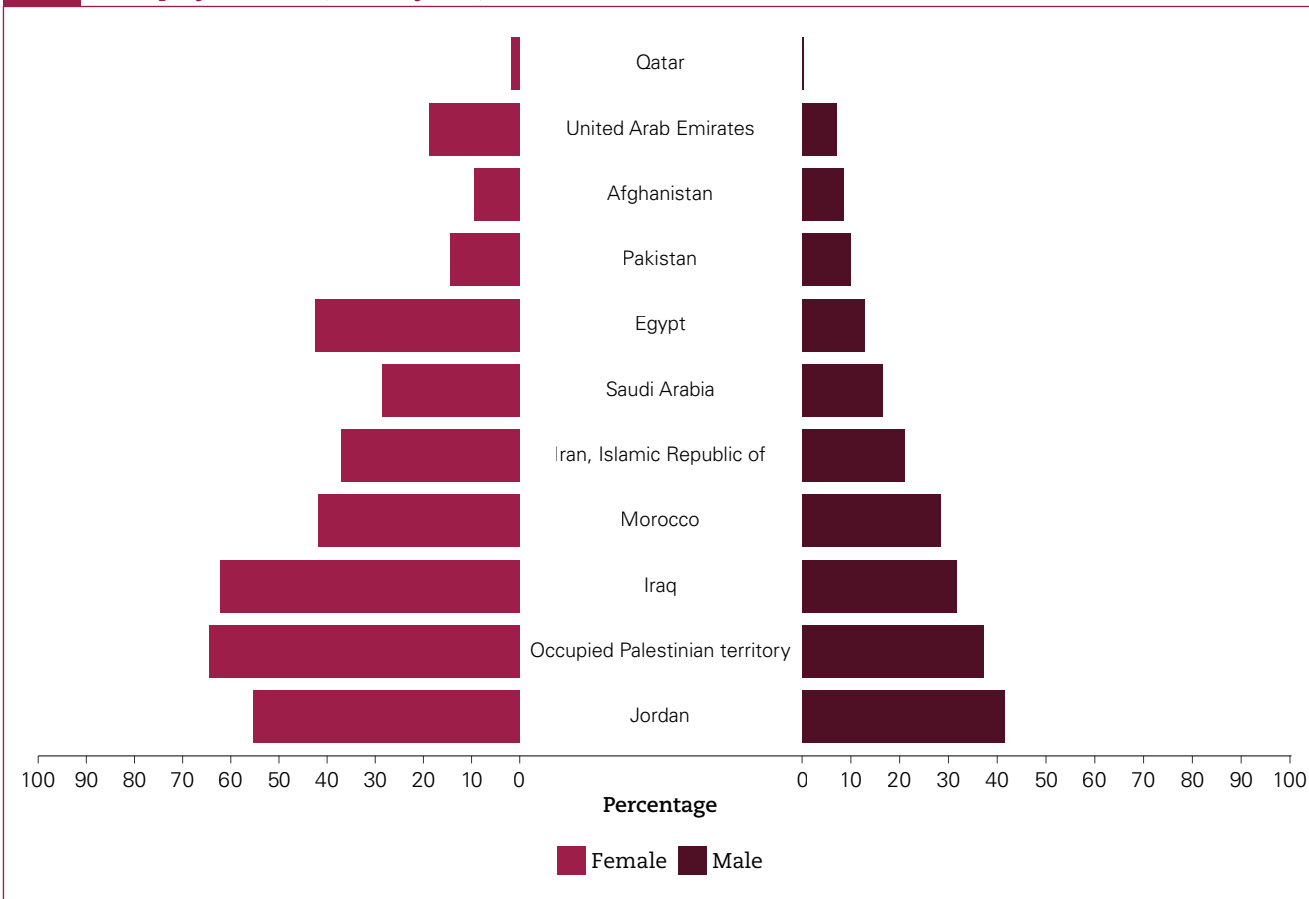
### Data sources

- ILO Data Explorer. SDG indicator 8.5.2 – Unemployment rate (%) - Annual (<https://www.ilo.org/shinyapps/bulkexplorer4/>)

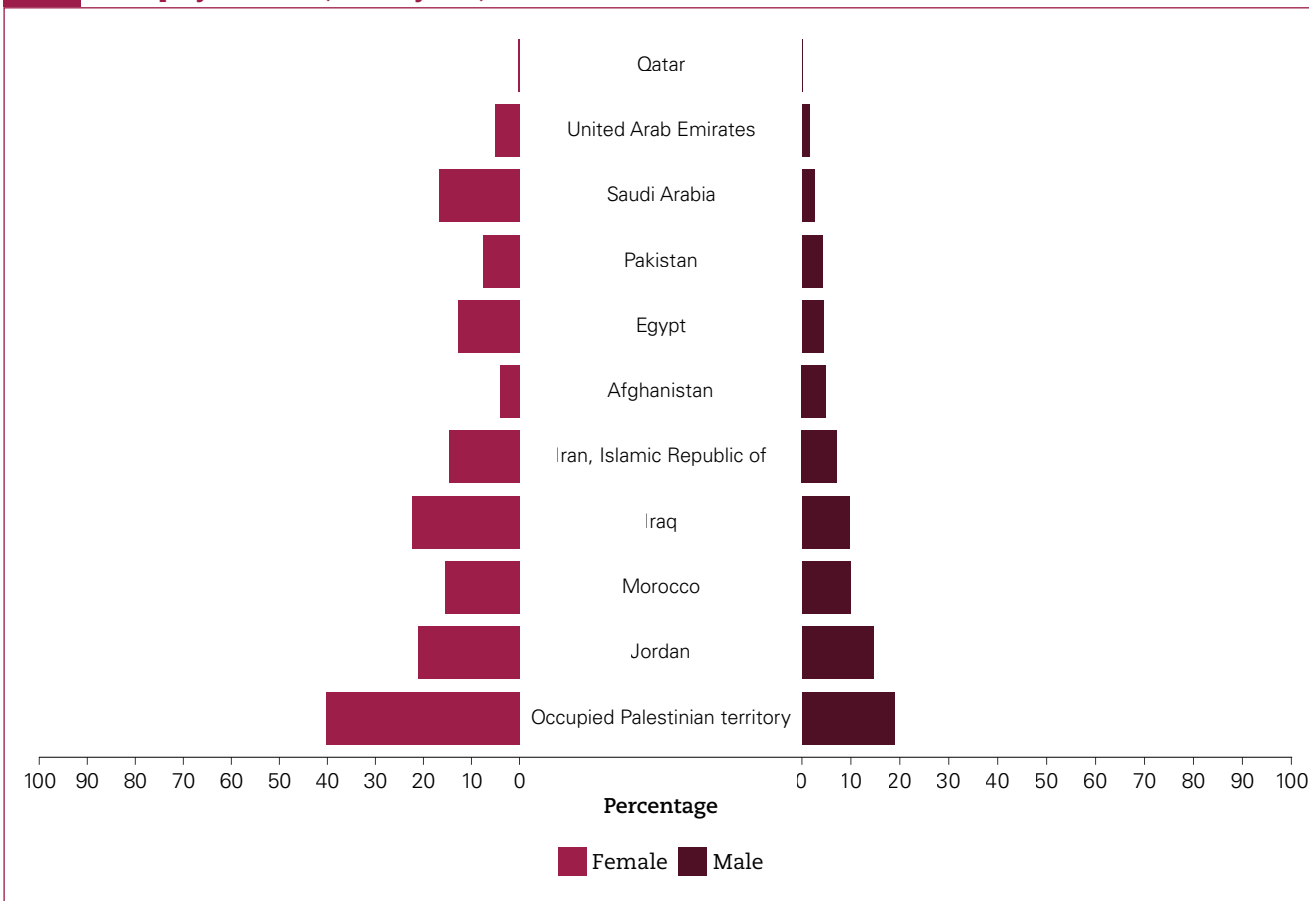
## 8.5.2 Unemployment rate by sex, 2021



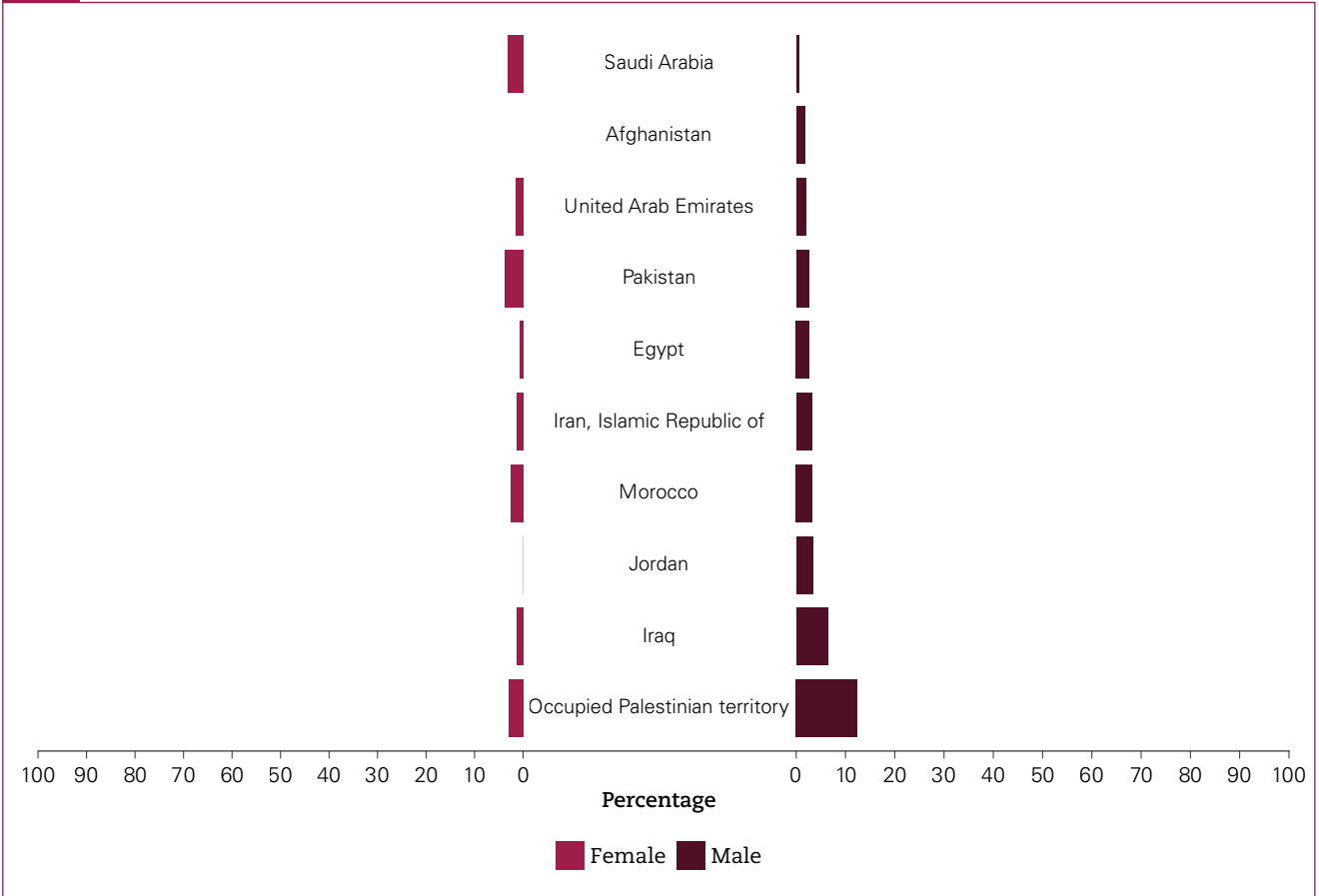
### 8.5.2 Unemployment rate, 15–24 years, 2021



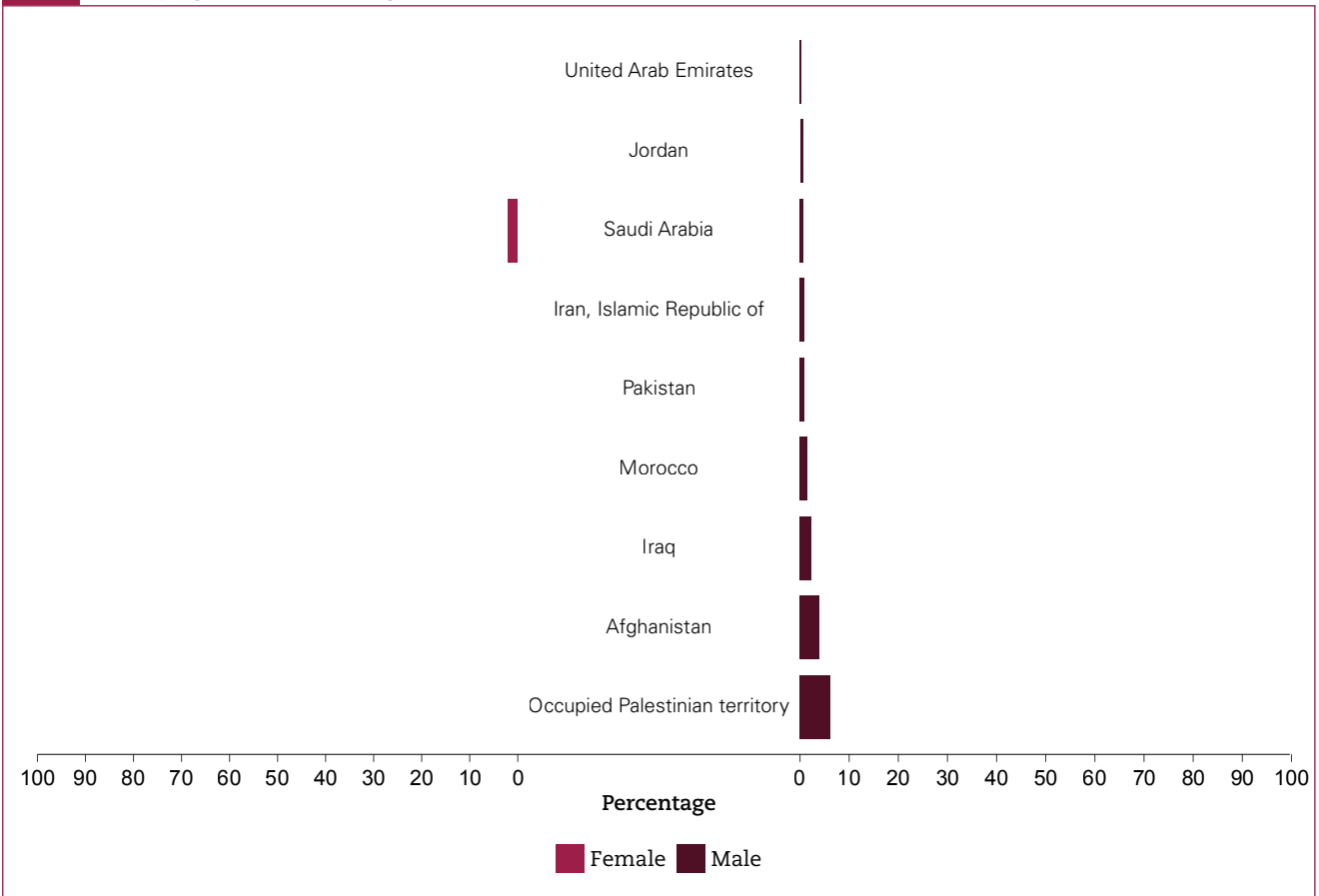
### 8.5.2 Unemployment rate, 25–54 years, 2021



### 8.5.2 Unemployment rate, 55–64 years, 2021



### 8.5.2 Unemployment rate, 65+ years, 2021





# Goal 11

## Make cities and human settlements inclusive, safe, resilient and sustainable

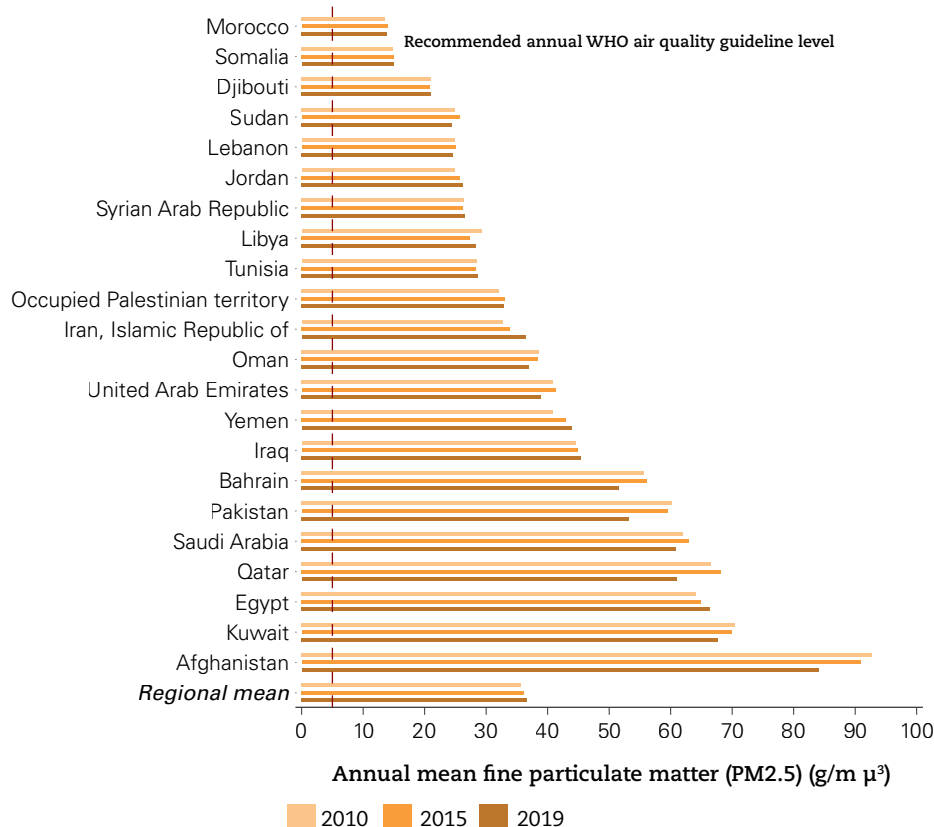
**Target 11.6:** By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management

■ **Indicator 11.6.2:** Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)

### Current situation

- The annual mean level of fine particulate matter (PM2.5) in urban areas in countries of the Region in 2019 ranged from 14 µg/m<sup>3</sup> in Morocco to 75 µg/m<sup>3</sup> in Afghanistan, with an average of 48 µg/m<sup>3</sup>.
- The annual mean level of fine particulate matter in urban areas in 11 countries of the Region in 2019 was below the WHO global air quality guidelines annual interim target 1 of 35 µg/m<sup>3</sup> and five countries were below annual interim target 2 of 25 µg/m<sup>3</sup>.
- In 2019, the annual mean level of fine particulate matter was below the recommended interim target 3 annual air quality guideline level of 15 µg/m<sup>3</sup> in urban areas in only two countries (Morocco and Somalia).
- The annual mean level of fine particulate matter in urban areas in all the countries of the Region in 2019 exceeded both the WHO recommended annual air quality guideline level of 5 µg/m<sup>3</sup> and the interim target 4 annual air quality guideline level of 10 µg/m<sup>3</sup>.
- The annual mean level of fine particulate matter (PM2.5) in urban areas increased in nine countries of the Region between 2010 and 2019, with the largest absolute increase (almost 3 µg/m<sup>3</sup>) in Yemen.
- Around 50% of the annual mean level of air pollution in the Region originates from natural sources such as sand, dust and sea salt, with the remainder generated by human activity (transport

### 11.6.2 Annual mean levels of fine particulate matter in cities, 2010–2019



and industry). That said, natural sources are deeply affected by human activity. Construction of dams leading to decreased water flow and deforestation have led to increased volumes of dust being released in the Region.

- In 2019, around 99% of the world's population was living in places where the WHO air quality guidelines levels were not met.
- Air pollution levels of particulate matter in urban areas of the Region are the highest of all WHO regions.
- Air quality levels in most Eastern Mediterranean countries (at the national level) have not significantly improved since 2010. However, based on reported values, air quality levels in urban areas have improved in some countries.

### Key messages

- Implement effective air quality management strategies that would reduce the major sources of air pollution, including natural sources affected by human activity, to meet WHO interim targets including rapidly phasing out health-harming subsidies for dirty fuels and polluting industries, redirecting investment to health-promoting and accessible alternatives, enforcing emissions standards, improving housing conditions and ensuring access to clean energy sources.

### Challenges

- Lack of health standards and surveillance. For example, the national ambient air quality standards in most countries in the Region are not based on the WHO health-based air quality guidelines.
- Increased population and air pollution-generating activities, including the expansion of transportation and industrial sectors.
- Infrastructural interventions leading to increased sand and dust being released (e.g. dam building).
- The available research on air pollution is limited in accurately measuring its primary sources and associated health impacts.
- Poor air quality management, monitoring, reporting and communication systems in most countries in the Region.
- Poor research on air pollution and health; lack of exposure-response functions in dusty environments.
- Poor commitment and coordination between the different related sectors.

- Emergencies, including conflict and prolonged civil unrest.

### Steps for accelerated action

- Build on the momentum generated by the 27th Conference of the Parties to the United Nations Framework Convention on Climate Change (COP27) that took place in November 2023 in Egypt to implement reforms and changes to reduce air pollution.
- Standardize air quality and health monitoring and surveillance networks.
- Evaluate the effectiveness of the current air quality management plans and update them accordingly.
- Conduct time series analysis to understand the health impact of air pollution in dusty environments.
- Address the major sources of air pollution in different contexts and resource settings. This may involve:
  - gathering evidence of the health impacts of natural air pollution (dust and sea salt particulate matter) and enhancing relevant mitigation interventions to allow for the development and management of national air quality standards;
  - rapidly phasing out health-harming subsidies for dirty fuels and polluting industries, and introducing penalties for polluters and/or taxes on pollution;
  - adopting and strictly enforcing emissions standards for all pollutants in all relevant sectors, including industry, energy, transport, waste and agriculture;
  - redirecting investment to health-promoting and accessible alternatives including clean transport and renewable energy; and
  - improving housing conditions and ensuring access to clean energy sources for indoor cooking, heating and lighting.

### Available guidance/tools

- Compendium of WHO and other UN guidance on health and environment, 2022 update (<https://www.who.int/publications/i/item/WHO-HEP-ECH-EHD-22.01>)
- WHO global air quality guidelines: particulate matter (PM2.5 and PM10), ozone, nitrogen dioxide, sulfur dioxide and carbon monoxide. 2021 (<https://www.who.int/publications/i/item/9789240034228>)

- WHO ambient air quality database, 2022 update: status report. 2023 (<https://www.who.int/publications/i/item/9789240047693>)
  - World Health Assembly, 71. Health, environment and climate change: road map for an enhanced global response to the adverse health effects of air pollution: report by the Director-General. World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/276321>)
  - Data Integration Model for Air Quality (DIMAQ) (<https://www.who.int/data/gho/data/themes/air-pollution/who-modelled-estimates-of-air-pollution-from-particulate-matter#:~:text=The%20Data%20Integration%20Model%20for,aerosol%20optical%20depth%20and%20chemical>)
- Key references**
- WHO. Ambient (outdoor) air pollution [Fact sheet]. 2022 ([https://www.who.int/news-room/fact-sheets/detail/ambient-\(outdoor\)-air-quality-and-health](https://www.who.int/news-room/fact-sheets/detail/ambient-(outdoor)-air-quality-and-health))
  - Karagulian F, Belis CA, Dora CFC, Prüss-Ustün AM, Bonjour S, Adair-Rohani H et al. Contributions to cities' ambient particulate matter (PM): a systematic review of local source contributions at global level. Atmospheric Environment. 2015;120:475–483 (<https://www.sciencedirect.com/science/article/pii/S1352231015303320>)
  - Hopke PK, Dai Q, Li L, Feng Y. Global review of recent source apportionments for airborne particulate matter. Science of The Total Environment. 2020 Oct 20;740:140091 (<https://www.sciencedirect.com/science/article/pii/S0048969720336111#ac0005>)
  - Arab Strategy and Framework of Action on Health and Environment 2017–2030. A regional strategy on health and environment for Arab states and an action guideline. League of Arab States in collaboration with WHO and the United Nations Environment Programme. Amman, Jordan 2017 [News] (<https://www.emro.who.int/ceha/ceha-news/summit-of-arab-league-adopts-arab-strategy-on-health-and-the-environment.html>)
- Data sources**
- WHO Global Health Observatory. SDG Indicator 11.6.2 Concentrations of fine particulate matter (PM2.5) ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/concentrations-of-fine-particulate-matter-\(pm2-5\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/concentrations-of-fine-particulate-matter-(pm2-5)))

# Goal 16

## Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

**Target 16.1:** Significantly reduce all forms of violence and related death rates everywhere

**Indicator 16.1.1:** Estimates of rates of homicides per 100 000 population, 2010–2019

**Current situation**

- There are wide variations in the levels and trends in rates of homicides in the Region.
- There were reductions of between 0.01 (in Syrian Arab Republic) and 2.3 (in Pakistan) percentage points in estimated rates of homicides in 15 countries of the Region between 2010 and 2019.
- There were increases of between 0.16 (in Morocco) and 3.99 (in Yemen) percentage points in estimated rates of homicides in 6 countries of the Region between 2010 and 2019.

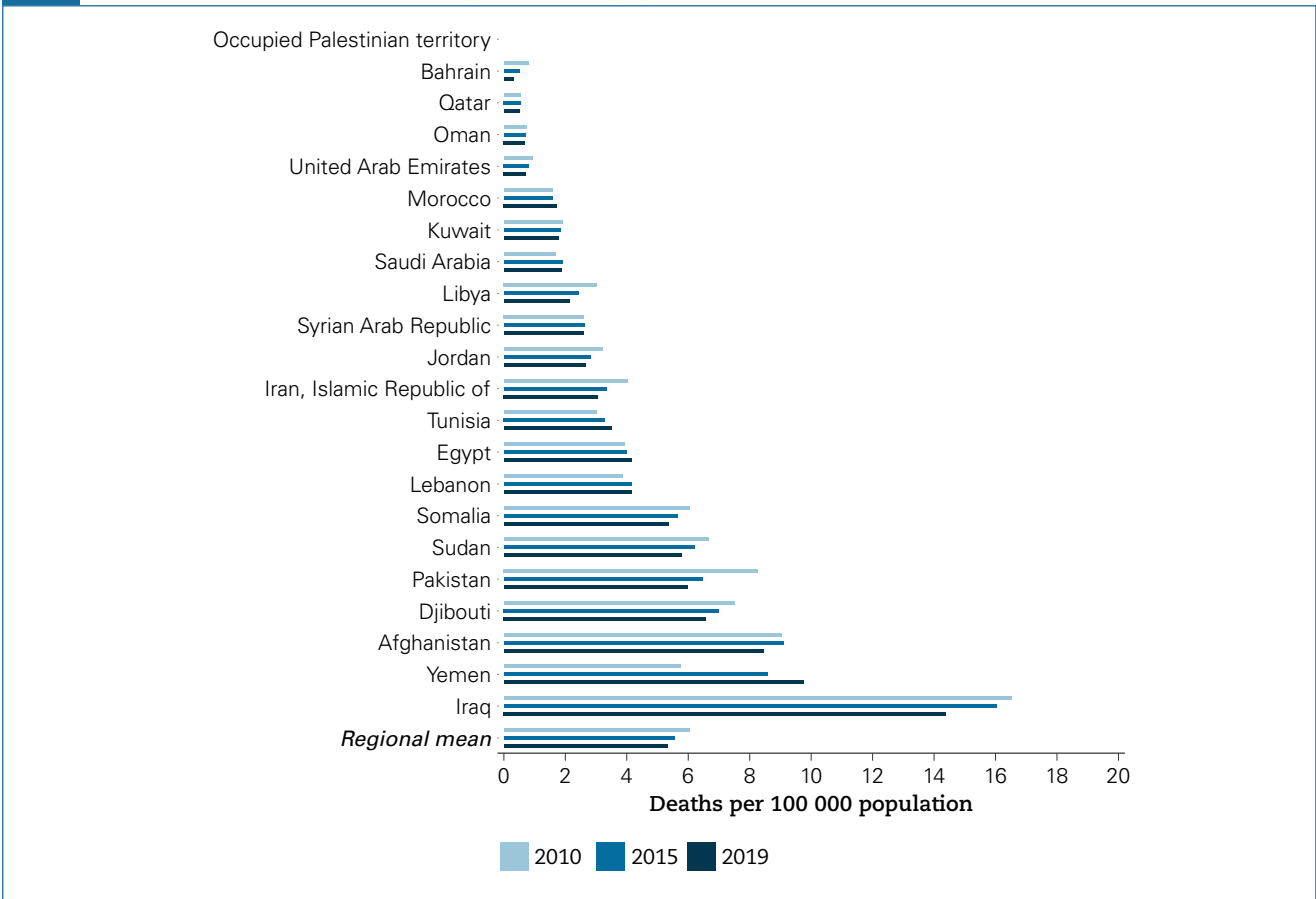
- Iraq had the highest estimated rate of homicides in the Region during the period 2010–2019.
- In 2019, the estimated rates of homicides in the Region ranged from 0.3 deaths per 100 000 population in Bahrain to 14.4 deaths per 100 000 population in Iraq.
- In half the countries of the Region the estimated rates of homicides were below 3.2 deaths per 100 000 population in 2010, below 3.3 deaths per 100 000 population in 2015 and below 3.1 deaths per 100 000 population in 2019.

**Key message**

**Challenges**

- Data availability and data quality vary among countries. These estimated rates are based on data provided by countries from police and vital

**16.1.1 Estimates of rates of homicides per 100 000 population, 2010–2019**



registration sources; data from UNODC's global studies on homicide; and data from WHO's Mortality Database. The estimation process used observed data on homicide rates and, for countries without sufficient data availability or quality, regression modelling to compute comparable estimates of homicide rates and numbers across countries.

### Steps for accelerated action

- Strengthen institutions and structures that create and sustain peaceful societies including a well-functioning government, sound business environment, and legal and cultural norms, recognizing the crucial importance of basic human rights, positive external relations, free flow of information, skilled human capital, low levels of corruption to enhance trust in institutions and the equitable distribution of resources (see Global Peace Index 2020 below).

### Available guidance/tools

- WHO Emergency Medical Teams Initiative [website]: <https://extranet.who.int/emt/>

- World report on violence and health: Abstract. Geneva: World Health Organization; 2002: <https://iris.who.int/handle/10665/67403>

### Key references

- UNODC, Global Study on Homicide. Vienna: United Nations Office on Drugs and Crime; 2019: <https://www.unodc.org/documents/data-and-analysis/gsh/Booklet2.pdf>
- Global Peace Index 2020. Measuring peace in a complex world. Sydney: Institute for Economics & Peace; 2020: [https://www.visionofhumanity.org/wp-content/uploads/2020/10/GPI\\_2020\\_web.pdf](https://www.visionofhumanity.org/wp-content/uploads/2020/10/GPI_2020_web.pdf)

### Data sources

- <https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimates-of-rates-of-homicides-per-100-000-population>

Goal  
16

**Target 16.2:** End abuse, exploitation, trafficking and all forms of violence against and torture of children

**Indicator 16.2.1:** Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month

**Current situation**

- Data currently available from household surveys do not capture the full age range specified in the SDG indicator, since data are not collected for adolescents aged 15 to 17 years.
- Cross-sectional data were available from 12 countries in the Region but only five countries had data for most recent years (2015–2020). Only one country (Lebanon) had more than a single data point.

- The proportion of children aged 1–14 years who had experienced physical punishment and/or psychological aggression by caregivers in the past month ranged from 57% (60% for males and 54% for females) in Lebanon to 93% (93% for both males and females) in Egypt.

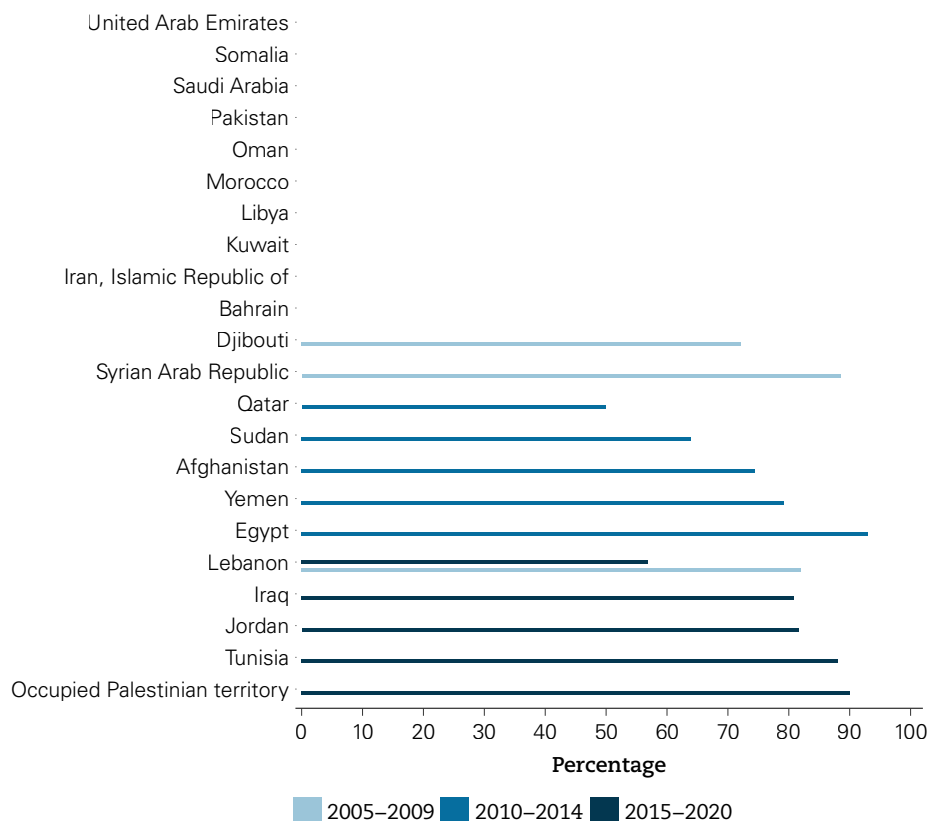
**Key message**

- Strengthen the health sector response as part of a multisectoral response aligned with WHO guidance by addressing risk factors and determinants of interpersonal violence, ensuring equitable access to health-care services and improving routine collection of data and evidence.

**Challenges**

- While many countries in the Region have mechanisms and funded plans to support national violence-prevention efforts, only one third of such countries have measurable targets.
- Further methodological work is needed to identify additional items on disciplinary practices relevant to older adolescents.

**16.2.1 Proportion of children aged 1-14 years who experienced physical violence, 2005–2020**

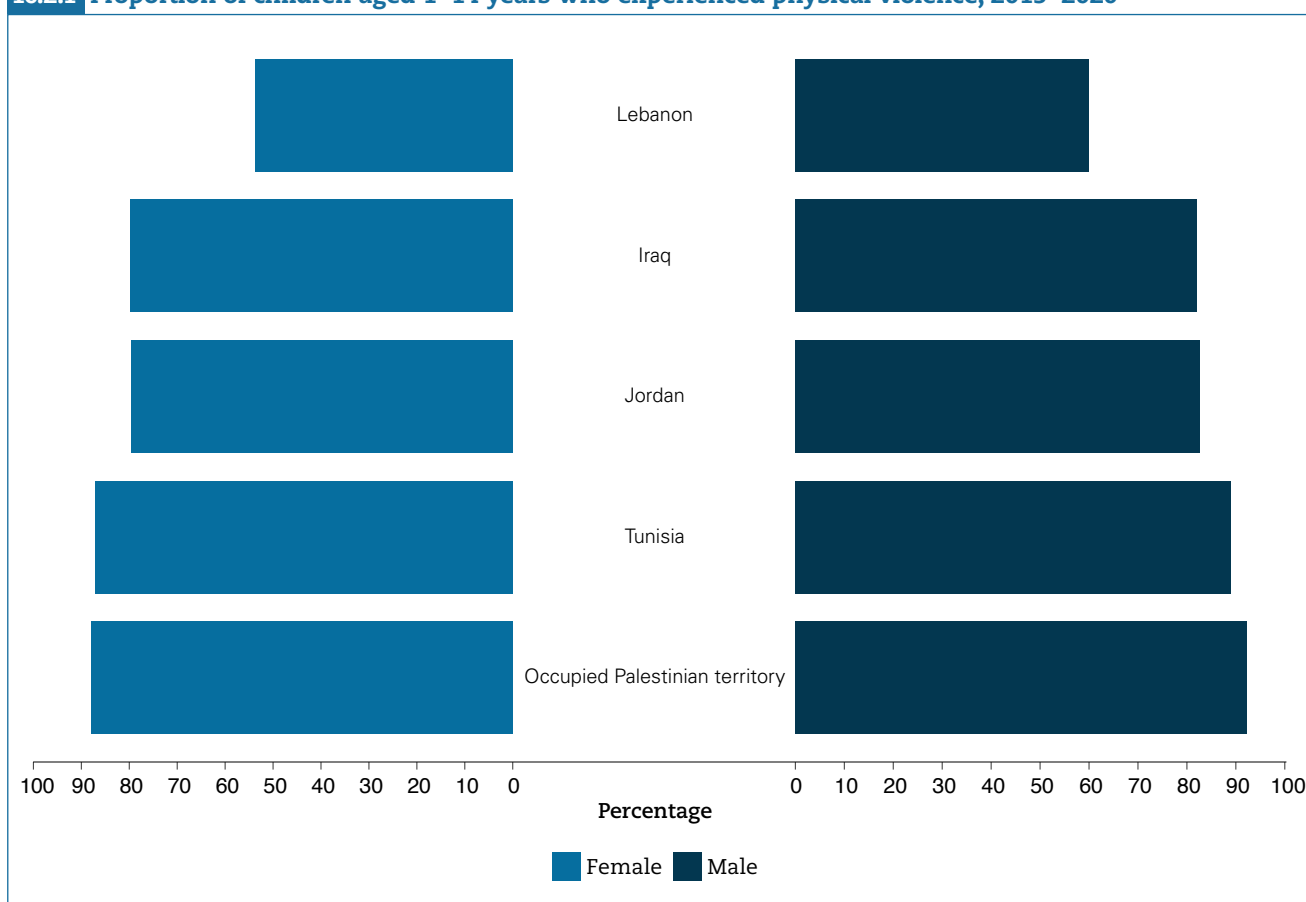


- Inadequate administrative data systems for reporting child homicides through official sources such as vital registry and police records.
- Selective implementation of the INSPIRE strategies.<sup>5</sup> Approaches related to implementation and enforcement of laws, response and support services, norms and values, and education and life skills are more supported than those on safe environment, income strengthening, and parent and caregiver support. Even where such approaches are supported, they have not yet reached all (or nearly all) of those who need them.
- Laws on violence against children are widely enacted but often inadequately enforced.
- The high burden of collective violence in the Region tends to draw attention away from the violence of everyday life that affects children and families.

### Steps for accelerated action

- Promote good governance and coordination to strengthen the potential of multisectoral action to prevent violence against children.
- Prioritize data collection on key violence-related indicators as part of regular SDG reporting and use these to set measurable targets in data-driven national action plans.
- Strengthen legislative frameworks and optimize their effectiveness in helping to end violence against children.
- Use evidence to enhance the effectiveness of prevention and service programming based on the INSPIRE strategies that provide a collection of both proven and promising approaches.
- Ensure adequate funding for evidence-based approaches to ending violence against children embedded in medium-term expenditure frameworks at national and subnational levels.

#### 16.2.1 Proportion of children aged 1–14 years who experienced physical violence, 2015–2020



<sup>5</sup> INSPIRE is a technical package and handbook for selecting, implementing and monitoring effective policies, programmes and services to prevent and respond to violence against children. It comprises seven evidence-based strategies on: Implementation and enforcement of laws; Norms and values; Safe environments; Parent and caregiver support; Income and economic strengthening; Response and support services; and Education and life skills. For more details please visit: <https://www.who.int/news-room/feature-stories/detail/preventing-violence-against-children-promotes-better-health>.

### Available guidance/tools

- Global partnership and fund to end violence against children [website] (<https://www.end-violence.org>)
- INSPIRE: Seven strategies for ending violence against children. WHO; 2016 (<https://www.who.int/publications/i/item/9789241565356>)
- INSPIRE Handbook: action for implementing the seven strategies for ending violence against children. WHO; 2018 (<https://www.who.int/publications/i/item/inspire-handbook-action-for-implementing-the-seven-strategies-for-ending-violence-against-children>)
- INSPIRE Indicator Guidance and Results Framework. UNICEF; 2018 (<https://www.who.int/publications/m/item/inspire-indicator-guidance-and-results-framework>)
- WHO Guidelines for the health sector response to child maltreatment. 2019 (<https://www.who.int/publications/m/item/who-guidelines-for-the-health-sector-response-to-child-maltreatment>)
- Responding to children and adolescents who have been sexually abused. WHO clinical guidelines (<https://www.who.int/publications/i/item/9789241550147>)
- Child maltreatment prevention course [online resource] (<https://www.who.int/teams/social-determinants-of-health/violence-and-injury-prevention-short-courses/child-maltreatment-prevention-course>)
- World Health Assembly, 69. WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children (<https://apps.who.int/iris/handle/10665/252785>)

### Key references

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- Global status report on preventing violence against children 2020. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/i/item/9789240004191>)

### Data sources

- UNICEF. Violent discipline (<https://data.unicef.org/topic/child-protection/violence/violent-discipline/>)



**Summary  
of findings**



Regional and country progress on the health-related SDG targets presented in the 33 fact sheets above and Table 1 below document a marked slowdown with setbacks across many indicators on health coverage, health risks and determinants, and health status compared to the 2020 report. As previously observed, the progress varies markedly between the countries and the impact of the pandemic has been felt differently across countries. Although efforts to improve quality of data and reporting have been made, such as correcting overly generous reporting of progress previously, the slower progress also reflects the negative impact of the COVID-19 pandemic, economic slowdown and ongoing complex emergencies faced by half the countries in the Region. Hence, the overall findings warrant further efforts at national and international levels to achieve the health-related SDGs at a wider scale. These findings can be summarized as below:

- **Only two of the 50 health-related SDG indicators profiled showed notable progress between 2015 and 2022 (or nearest years)**

The Region overall and 14 countries within it have reached the target for wasting among children under 5 years of age of less than 5% (set for 2025). The proportion of births attended by skilled health personnel has increased from 75% to 85% and has reached almost universal (over 90%) in 14 countries.

- **Progress has been too slow on 21 of the health-related SDG indicators to reach the targets**

As examples, although 13 countries have met the maternal mortality ratio 2030 target (< 70 deaths per 100 000 live births), regional progress remains slow (2015: 196; and 2020: 179) with six countries reporting an MMR of more than 140 deaths per 100 000 live births. Although stunting rates for children under 5 years of age declined (2030 target: 0; 2015: 29%, 2022: 25%), progress is too slow. Faint progress has been made in improving access to sanitation facilities to meet global targets (2015: 42.5%, 2020: 45.1%) and the proportion of the population using safely managed sanitation services in the Region is less than 50% in seven countries of the Region.

- **Progress has stalled or is worsening on 16 indicators**

As examples, no clear progress has been made in reducing mortality rates due to NCDs (2015: 25.8%; 2019: 24.5%; versus the 2030 target of 17.2%) despite NCDs being among the major causes of the burden of disease in the Region. High out-of-pocket payments causing financial hardship is an issue that has not improved and remains a key area for policy action.

*In addition to the above, there are key messages to highlight.*

- **In terms of enhancing health coverage, progress was too slow, or stalled, on most of the 20 health coverage indicators to meet the 2030 targets.**

There were modest improvements in the regional mean coverage of health services and the proportion of the households facing financial hardship due to high out-of-pocket payments. Similarly, modest increases were reported for health-care personnel, though six countries have a health workforce density below the global median of 49 per 10 000 population. By 2020, two thirds of women of reproductive age had their need for family planning satisfied with modern methods in six countries, only one more country than in 2010. Although vaccination rates have improved with high coverage (at least 90%) in half the countries, they declined in the other half. Given the numerous disease outbreaks and emergencies, including natural disasters, IHR capacity and health emergency preparedness is still lacking in half the countries of the Region.

- **Despite some positive signs in a few countries in terms of addressing risk factors for health, progress is slow or stalled.** A high portion of children under 5 continue to face malnutrition: stunting rates for children under 5 are declining too slowly to meet the zero-prevalence target for 2030 and although there are limited data points, progress has stalled in reducing the percentage of children under 5 years of age who are overweight, with nearly half of countries experiencing increases. Minimal improvements were seen in air pollution and water and sanitation at the regional level despite marked improvements in a handful of countries. Air pollution in the Region is largely due to human activity;

## Summary of findings

transport and industry are major causes and although air pollution also comes from natural sources, these are also deeply affected by human activity such as the construction of dams and deforestation.

**Due to limited data, progress could not be reported for most of the eight social determinants of health including poverty, education, and gender equality.** Less than 2 in 3 children in the Region do not achieve minimum reading proficiency despite a similar proportion completing primary education. Up to 53 million ever-married/partnered women aged 15–49 in the Region experienced physical and/or sexual violence from a current or former husband or male partner at least once in their lifetime. The unemployment rate over the past ten years, around 8%, has stagnated with higher rates observed for women than men and the highest rates seen among young adults aged 15–24 years.

**Progress has stalled or worsened on 11 of the 15 morbidity and mortality indicators.** The increase in the proportion of births attended by skilled health personnel and the decline in adolescent birth rate paint a positive picture. However, mortality indicators demonstrate a more complex situation. Although 13 countries have met the MMR 2030 target (under 70 deaths per 100 000 live births), regional progress remains slow with six countries reporting an MMR of more than double the 2030 target. Regional progress for the under-5 mortality rate is also too slow to meet the 2030 target. The situation is worsening for communicable diseases targeted for elimination including HIV, malaria and neglected tropical diseases like leishmaniasis. However, most concerning is that no progress has been made in reducing mortality rates due to NCDs, despite these being among the major causes of the burden of disease in the Region.

**Vast differences among countries in the Region are reflected in the progress on health-related SDG indicators at country level.** Negligible improvements were seen in the UHC service coverage index at the regional level, increasing by 10 or more points in Egypt, Islamic Republic of Iran and Qatar between 2010 and 2019. In five countries, neonatal mortality decreased by one third or more;

however, in seven countries the rate is double the global target. Likewise, in 16 countries, the under-5 mortality rate was equal to or lower than the 2030 target (< 25 deaths per 1000 live births) but exceeds double the global target in six countries. Although Bahrain, Oman, Qatar and the United Arab Emirates met the global target of halving the 2010 mortality rate from road traffic injuries, the Region as a whole missed the target.

**Although trend data is available for three quarters of indicators, one in five of the latest data points is from 2019 or earlier, which hampers the ability to monitor trends.** For a few indicators, like mortality from road traffic injuries, only one data point is available since 2019 while for other indicators, very few countries from the Region reported progress. This includes the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. Limited data on poverty, education and gender equality make it difficult to address the determinants of health.

**Finally, limited disaggregated data impedes efforts to promote health equity through gender- and equity-sensitive policies and programmes.** Most outcome indicators had gender disaggregation (e.g. under-5 mortality; the probability of dying between age 30 and exact age 70 from any of cardiovascular disease, cancer, diabetes, or chronic respiratory disease); some risk factors had geographical disaggregation but mainly focused on urban/rural dimensions (e.g. annual mean levels of fine particulate matter) while some determinants had limited disaggregation by age group (e.g. unemployment). Data disaggregation by gender, age, income, place of residence and other important variables (e.g. refugee status) is critical for generating information through a gender and equity lens to inform public health action and leave no one behind.

A detailed summary of the extent of regional progress being made on all of the health-related SDG indicators is presented in Table 1.

**Table 1.** Summary of progress on the health-related SDGs, 2015 to 2022

Health-related SDG indicator	2015 (or nearest)	Baseline year	Mid-value (if available)	Mid-value year	2022 (or nearest)	Latest year	Target by 2030 (if available)	Status of progress 2023
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### Mortality

<b>3.1.1</b> Maternal mortality ratio (per 100 000 live births)	196	2015	187	2018	179	2020	70	Progress made but too slow to meet target
<b>3.1.2</b> Births attended by skilled health personnel (%)	75	2015	82	2020	85	2022		Progress
<b>3.2.1</b> Under-5 mortality rate (per 1000 live births)	52.3	2015	48.4	2018	45.22	2021	25	Progress made but too slow to meet target
<b>3.2.2</b> Neonatal mortality rate (per 1000 live births)	28	2015	26.5	2018	25.2	2021	12	Progress made but too slow to meet target
<b>3.4.1</b> Probability of dying from NCD (between ages 30 and 69) (%)	25.75	2015	24.96	2017	24.53	2019	17.17	Progress stalled/ situation worsening
<b>3.4.2</b> Suicide mortality rate (per 100 000 population)	6.1	2015	6	2017	5.9	2019	4.1	Progress made but too slow to meet target
<b>3.6.1</b> Mortality rate from road traffic injuries (per 100 000 population)	17.96	2015	17.6	2017	17.82	2019	8.98	Progress stalled/ situation worsening
<b>3.9.1</b> Mortality rate attributed to household and ambient air pollution (per 100 000 population)					136	2019	"Substantially reduce"	Trend not reported
<b>3.9.2</b> Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (per 100 000 population)					18.44	2019	"Substantially reduce"	Trend not reported
<b>3.9.3</b> Mortality rate attributed to unintentional poisoning (per 100 000 population)	1.22	2015	1.14	2017	1.11	2019	"Substantially reduce"	Progress made but too slow to meet target

### Morbidity

<b>3.3.1</b> New HIV infections (per 1000 uninfected people)	0.053	2015			0.061	2021	0	Progress stalled/ situation worsening
<b>3.3.2</b> TB incidence (per 100 000 population)	119	2015	114	2018	112	2021	0	Progress made but too slow to meet target
<b>3.3.3</b> Malaria incidence (per 1000 population at risk)	9.04	2015	11.18	2018	11.6	2021	0	Progress stalled/ situation worsening
<b>3.3.4</b> Hepatitis B prevalence among children under 5 years of age (per 100 000 population)					0.84	2020	"Combat"	Trend not reported
<b>3.3.5</b> Number of people requiring interventions for leishmaniasis	160 205	2015			179 520	2021	0	Progress stalled/ situation worsening

## Summary of findings

Health-related SDG indicator	2015 (or nearest)	Baseline year	Mid-value (if available)	Mid-value year	2021 (or nearest)	Latest year	Target by 2030 (if available)	Status of progress 2023
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### SDG 3 means of implementation of targets

<b>3.5.2</b> Harmful alcohol use (litres of pure alcohol per capita ≥ 15 years of age)	0.29	2015			0.31	2019	"Strengthen the prevention of harmful use"	Progress stalled/ situation worsening
<b>3.7.1</b> Women of reproductive age (15–49 years) who had their need for family planning satisfied with modern methods (%)	55.5	2015	56.2	2017	57.5	2020	100	Progress made but too slow to meet target
<b>3.7.2</b> Adolescent birth rate (per 1000 women aged 15–19 years)	54.03	2015	50.23	2018	45.78	2022	na	Progress
<b>3.8.1</b> UHC service coverage index	53	2015	56	2017	57	2021	100	Progress made but too slow to meet target
<b>3.8.2</b> Large household expenditure as a share of total health care expenditure (> 10%)	12.86	2015	13.18	2017	12.11	2019	0	Progress stalled/ situation worsening
<b>3.8.2</b> Large household expenditure as a share of total health care expenditure (> 25%)	16.14	2015	19.05	2017	16.43	2019	0	Progress stalled/ situation worsening
<b>3.a.1</b> Prevalence of tobacco use among persons 15 years and older (%)	20.2	2015	19.6	2018	18.6	2020	0	Progress made but too slow to meet target
<b>3.b.1</b> DTP3 coverage (%)	80	2015	84	2018	82	2021	100	Progress made but too slow to meet target
<b>3.b.1</b> MCV2 coverage (%)	68	2015	74	2018	77	2021	100	Progress made but too slow to meet target
<b>3.b.1</b> PCV3 coverage (%)	38	2015	47	2018	51	2021	100	Progress made but too slow to meet target
<b>3.b.2</b> Official development assistance for medical research per capita (US\$)					3.16	2021		Trend not reported
<b>3.b.3</b> Availability of essential medicines in public health facilities (%)					76.3	2021	100	Trend not reported
<b>3.c.1</b> Density of physicians (per 10 000 population)	10.46	2015			13.86	2021	"Substantially increase"	Progress made but too slow to meet target
<b>3.c.1</b> Density of pharmacists (per 10 000 population)	3.92	2015			4.37	2021	"Substantially increase"	Progress made but too slow to meet target
<b>3.c.1</b> Density of nurses (per 10 000 population)	15.33	2015			17.2	2021	"Substantially increase"	Progress made but too slow to meet target

## Summary of findings

Health-related SDG indicator	2015 (or nearest)	Baseline year	Mid-value (if available)	Mid-value year	2021 (or nearest)	Latest year	Target by 2030 (if available)	Status of progress 2023
<b>3.c.1</b> Density of dentists (per 10 000 population)	2.24	2015			2.38	2021	"Substantially increase"	Progress made but too slow to meet target
<b>3.d.1</b> International Health Regulations (2005) capacity and health emergency preparedness					65	2021	na	Trend not reported
<b>3.d.2.a</b> Percentage of blood stream infections due to selected antimicrobial-resistant organisms (due to ESBL- <i>E. coli</i> )			80	2017	78	2020	na	Progress stalled/ situation worsening
<b>3.d.2.b</b> Percentage of blood stream infections due to selected antimicrobial-resistant organisms (due to MRSA)			54.9	2017	72	2020	na	Progress stalled/ situation worsening

### Risk factors for health (direct effect on health)

<b>2.2.1</b> Stunting among children under 5 (%)	28.9	2015	27.1	2018	25.1	2022	0	Progress made but too slow to meet target
<b>2.2.1</b> Wasting among children under 5 (%)	3.1	2015			2.9	2021	0	Progress made but too slow to meet target
<b>2.2.2</b> Overweight among children under 5 (%)	7.1	2015			6.9	2022	0	Progress stalled/ situation worsening
<b>6.1.1</b> Access to improved drinking-water (%)	55.16	2015	55.35	2018	55.65	2020	100	Progress stalled/ situation worsening
<b>6.2.1</b> Access to improved sanitation facilities (%)	41.52	2015	43.79	2018	45.11	2020	100	Progress made but too slow to meet target
<b>11.6.2</b> Annual mean levels of fine particulate matter in cities ( $\mu\text{g}/\text{m}^3$ )	49.46	2015	48.3	2017	48.03	2019	15	Progress made but too slow to meet target
<b>16.1.1</b> Estimates of rates of homicides per 100 000 population	6.01	2010	5.52	2015	5.3	2019	"Significantly reduce"	Progress made but too slow to meet target
<b>16.2.1</b> Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers (%)					82	2015-2018	0	Trend not reported

### Determinants of health (indirect effect on health)

<b>1.1.1</b> Proportion of population living below the international poverty line (%)							0	Trend not reported
<b>4.1.1</b> Proportion of children at the end of primary achieving at least a minimum proficiency level in reading, total and by sex					58.6	2016	100	Trend not reported

## Summary of findings

Health-related SDG indicator	2015 (or nearest)	Baseline year	Mid-value (if available)	Mid- value year	2021 (or nearest)	Latest year	Target by 2030 (if available)	Status of progress 2023
<b>4.1.2</b> Completion rate primary education, total and by sex	70.7	2015	68.3	2020	69.9	2020	100	Progress stalled/ situation worsening
<b>5.2.1</b> Proportion of ever-partnered women and girls aged 15 years and older subjected to violence (%)					17	2018	0	Trend not reported
<b>5.6.1</b> Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (%)							100	Trend not reported
<b>8.5.2</b> Unemployment rate, males (%)	5.9	2015	6.1	2018	7	2021		Progress stalled/ situation worsening
<b>8.5.2</b> Unemployment rate, females (%)	14.6	2015	12.9	2018	13.9	2021		Progress stalled/ situation worsening
<b>8.5.2</b> Unemployment rate, both sexes (%)	7.8	2015	7.4	2018	8.3	2021		Progress stalled/ situation worsening



**Way  
forward**



As a Region, we were living longer in 2019 (almost 70 years) than we were in 2015 (68 years), and in 2023 we probably have longer life expectancies although the latest estimates are not yet out especially in light of pandemic effects on the Region. Eighty-five per cent of births in our Region are attended by skilled personnel and a greater proportion of children reach the age of five. However, too many women are still dying in childbirth. An unacceptable proportion of children are either stunted or wasted, and too many children and adults are overweight. Partly as a result of the latter, we have not been able to reduce the number of adults dying either due to cardiovascular disease, cancer, diabetes, or chronic respiratory disease. Neither have we been able to eradicate major infectious diseases like TB, HIV and malaria. Our water, including water being used for farming purposes, is increasingly unsafe and so is the air we breathe.

These perspectives are not to deny the progress made on different SDGs within different countries. They demonstrate the need for more and stronger action for better results. Even the progress observed on a few SDG indicators is not equally apparent in all countries of the Region. More problematic is the level of geographic, income- and gender-related inequality observed within countries. The fact that most of these are still difficult to report on due to limited data coverage makes it more challenging to note the progress made within countries and to monitor when a sector of the population is more likely to be left behind and exposed to higher levels of risk, lower levels of access and worse outcomes. The SDGs and the WHO vision are about health for all, by all. Reducing inequities is the cornerstone of all these laudable objectives. An important step forward is therefore to improve the availability of disaggregated data that allows us to monitor and reduce inequities by enabling relevant evidence-informed policy changes and implementation.

We are at the halfway point for the SDG agenda: if we want change, then we need to take bold steps to reverse current trends. We see some successes and achievements in the countries of the Eastern Mediterranean, some of which are described in further detail in the regional health profile (1). However, as a Region, we are far from reaching the health-related SDG targets. Ensuring the health and well-being of our population demands that we take a

more strategic approach, addressing upstream issues and the risks and determinants of health.

Strong government leadership is key to optimize co-benefits across all SDGs from all sectors, as described in the 2020 report. Investing in multisectoral Health-in-all-Policies is needed to address environmental determinants like climate change, air pollution, safe drinking-water and food security and to address issues related to social determinants such as poverty, education and gender inequality. Addressing NCDs, the biggest single health burden in the Region, means taking much stronger multisectoral action to address behavioural risks for NCDs while improving access to NCD care in both stable and emergency settings. Strengthening partnerships and community engagement as part of a multisectoral approach to promote health and well-being can address stigma and discrimination related to some communicable diseases and mental health as well as the risks and determinants of interpersonal violence; it can also enhance in the delivery of integrated essential services of good quality, particularly to the most at-risk populations. New opportunities such as climate-sensitive donor funding, new ways of working with civil society and other stakeholders, and technological advances for better outreach provide the impetus to optimize co-benefits across all SDGs.

The COVID-19 pandemic was a stark reminder of the importance of continuity of essential health services over the life-course in stable and emergency settings. We learned that inequalities persist with disadvantaged groups having less access to services. Achieving universal health coverage requires good governance for greater transparency and accountability, as well as provision of financial protection at national level. Effective and people-centred provision of health services requires availability and equitable distribution of health-care workforce and services, essential medicines, vaccines and diagnostics. For an emergency-affected region like ours, continuity and coverage of essential health services in emergency and humanitarian settings, which includes sexual and reproductive health, NCDs and mental health services, is imperative, while we continue to strengthen health systems and improve organized and integrated pre-hospital and facility-based emergency and trauma care systems.

## Way forward

The pandemic also taught us the importance of adopting an all-hazards, whole-of-government approach to public health preparedness and response in order to maintain resilient health systems.

Negotiations on an international pandemic treaty and updating the International Health Regulations (2015) are taking place as this report is being prepared, which will ensure countries are better prepared for and able to respond to future emergencies and outbreaks. National Action Plans for Health Security can be updated in the context of the pandemic response and sufficiently resourced to enhance needed health system strengthening and the regional health security agenda.

Data is a key source of national decision-making. Evidence-informed policy should be the norm in all countries, regardless of level of per capita income and infrastructure. As described in the 2020 report, limited data availability including dependence on data that is more than five years old hampers the ability to monitor trends. Limited data disaggregation by key stratifiers such as gender, age, income and place of residence impedes efforts to promote health equity. Increasing investment and strengthening health information systems will enable the timely collection, analysis and use of disaggregated data, estimates and forecasts to monitor key components of universal health coverage (health systems, infectious disease, NCDs, and reproductive, maternal, newborn and child health) as well as determinants, risk factors and health outcomes. Better planned household health surveys, better tailored to country needs can ensure

timely and quality data are available and that equity concerns can be investigated. Strengthening civil registration and vital statistics systems including certification and reporting of cause of death will facilitate their use for setting measurable targets in data-driven national action plans.

In summary, the way forward requires bold action across four areas: (i) advancing universal health coverage by investing in quality, accessible and integrated health services over the life-course; (ii) adopting an all-hazards, whole-of-government approach to public health preparedness and response; (iii) addressing health risks and determinants by promoting comprehensive multisectoral coordination policies and mechanisms to adopt and implement; and (iv) expanding evidence-based and data- and research-informed gender- and equity-sensitive policy-making. These measures are not new. They were spelt out in the previous reports and have been addressed in WHO governing body conferences convened by Member States and the Secretariat. We have learnt from the painful experiences of the COVID-19 pandemic. We can renew our commitment to achieving the health-related SDGs, focus on public health areas that have stalled or regressed and embrace opportunities provided by technological advancements, stronger partnerships like the Regional Health Alliance and increased integration and efficiency. Together it is possible to accelerate our efforts and achieve the health-related SDGs in the Eastern Mediterranean Region, and realize our vision of health for all by all.

## Key references

1. WHO Regional Office for the Eastern Mediterranean, Health and well-being profile of the Eastern Mediterranean Region, An overview of the health situation in the Region and its countries in 2019. 2020: Cairo, Egypt

# Annex 1

## Data sources for the health-related SDG indicators

### 1.1.1 Proportion of population living below international poverty line

- The World Bank Open Data [online database] (<https://data.worldbank.org/indicator/SI.POV.DDAY?view=chart>, accessed 16 August 2023).

### 2.2.1 Prevalence of stunting (height for age < -2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-jme-country-children-aged-5-years-stunted-\(-height-for-age-2-sd\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-jme-country-children-aged-5-years-stunted-(-height-for-age-2-sd)), accessed 16 August 2023).

### 2.2.2 Prevalence of wasting among children under 5 years of age

- The Global Health Observatory [online database]. Geneva: World Health Organization (<https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/prevalence-of-malnutrition-in-children>, accessed 16 August 2023).

### 2.2.3 Prevalence of overweight among children under 5 years of age

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-jme-country-children-aged-5-years-overweight-\(-weight-for-height-2-sd\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-jme-country-children-aged-5-years-overweight-(-weight-for-height-2-sd)), accessed 16 August 2023).

### 3.1.1 Maternal mortality ratio

- Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division; (<https://www.who.int/publications/i/item/9789240068759>)
- Levels and Trends of Maternal Mortality: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division; (<https://mmr2020.srhr.org/>)

### 3.1.2 Proportion of births attended by skilled health personnel

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/Indicator/TermID/94>, accessed 16 August 2023).

### 3.2.1 Under-five mortality

- Levels and trends in child mortality. Report 2022: Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2022: ([https://data.unicef.org/wp-content/uploads/2023/01/UN-IGME-Child-Mortality-Report-2022\\_Final-online-version\\_9Jan.pdf](https://data.unicef.org/wp-content/uploads/2023/01/UN-IGME-Child-Mortality-Report-2022_Final-online-version_9Jan.pdf))
- Stillbirth and Child Mortality Estimates [online database]. New York: IGME: UN Inter-agency Group for Child Mortality Estimation: (<https://childmortality.org/data>)
- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/themes/topics/sdg-target-3\\_2-newborn-and-child-mortality](https://www.who.int/data/gho/data/themes/topics/sdg-target-3_2-newborn-and-child-mortality), accessed 16 August 2023).

### 3.2.2 Neonatal mortality

- Levels and trends in child mortality. Report 2022: Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2022: ([https://data.unicef.org/wp-content/uploads/2023/01/UN-IGME-Child-Mortality-Report-2022\\_Final-online-version\\_9Jan.pdf](https://data.unicef.org/wp-content/uploads/2023/01/UN-IGME-Child-Mortality-Report-2022_Final-online-version_9Jan.pdf))
- Stillbirth and Child Mortality Estimates [online database]. New York: IGME: UN Inter-agency Group for Child Mortality Estimation: (<https://childmortality.org/data>)
- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/themes/topics/sdg-target-3\\_2-newborn-and-child-mortality](https://www.who.int/data/gho/data/themes/topics/sdg-target-3_2-newborn-and-child-mortality), accessed 16 August 2023).

### 3.3.1 New HIV infections

- Global data on HIV epidemiology and response [online database]. Geneva: UNAIDS. (<https://aidsinfo.unaids.org/>, accessed 16 August 2023).

### 3.3.2 Tuberculosis incidence

- Global tuberculosis report 2022. Geneva: World Health Organization; 2022. (<https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2022>; accessed 16 August 2023)
- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/incidence-of-tuberculosis-\(per-100-000-population-per-year\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/incidence-of-tuberculosis-(per-100-000-population-per-year))), accessed 16 August 2023).

### 3.3.3 Malaria incidence

- World malaria report 2022. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO (<https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2022>; accessed 16 August 2023)

### 3.3.4 Viral hepatitis

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hepatitis-b-surface-antigen-\(hbsag\)-prevalence-among-children-under-5-years](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hepatitis-b-surface-antigen-(hbsag)-prevalence-among-children-under-5-years), accessed 16 August 2023).

### 3.3.5 Number of people requiring interventions against neglected tropical diseases [leishmaniasis]

- The Global Health Observatory [online database]. Geneva: World Health Organization (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/number-of-cases-of-cutaneous-leishmaniasis-reported>; <https://www.who.int/data/gho/data/indicators/indicator-details/GHO/number-of-cases-of-visceral-leishmaniasis-reported>, accessed 16 August 2023).

### 3.4.1 Premature mortality from noncommunicable diseases

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/probability-of-dying-between-exact-ages-30-and-70-from-any-of-cardiovascular-disease-cancer-diabetes-or-chronic-respiratory-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/probability-of-dying-between-exact-ages-30-and-70-from-any-of-cardiovascular-disease-cancer-diabetes-or-chronic-respiratory-(-)), accessed 16 August 2023).

### 3.4.2 Suicide mortality

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/suicide-mortality-rate-\(per-100-000-population\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/suicide-mortality-rate-(per-100-000-population)), accessed 16 August 2023).

### 3.5.2 Harmful use of alcohol

- The Global Health Observatory [online database]. Geneva: World Health Organization (<https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/other-risk-factors—alcohol>, accessed 16 August 2023).

### 3.6.1 Mortality from road traffic injuries

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-road-traffic-death-rate-\(per-100-000-population\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-road-traffic-death-rate-(per-100-000-population)), accessed 16 August 2023).

### 3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods

- UN Population Division Data Portal: (<https://population.un.org/dataportal/home>, accessed 16 August 2023).

### 3.7.2 Adolescent birth rate

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adolescent-birth-rate-\(per-1000-women-aged-15-19-years\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adolescent-birth-rate-(per-1000-women-aged-15-19-years)), accessed 16 August 2023).

### 3.8.1 Universal health coverage (UHC) service coverage index

- The Global Health Observatory [online database]. Geneva: World Health Organization (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage>, accessed 16 August 2023).

### 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-10-of-total-household-expenditure-or-income-\(sdg-3-8-2\)-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-10-of-total-household-expenditure-or-income-(sdg-3-8-2)-(-)), accessed 16 August 2023).

### 3.9.1 Mortality rate attributed to household and ambient air pollution

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/ambient-and-household-air-pollution-attributable-death-rate-\(per-100-000-population-age-standardized\)\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/ambient-and-household-air-pollution-attributable-death-rate-(per-100-000-population-age-standardized)))).

### 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/mortality-rate-attributed-to-exposure-to-unsafe-wash-services-\(per-100-000-population\)-\(sdg-3-9-2\)\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/mortality-rate-attributed-to-exposure-to-unsafe-wash-services-(per-100-000-population)-(sdg-3-9-2)))).

### 3.9.3 Mortality rate attributed to unintentional poisoning

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/mortality-rate-attributed-to-exposure-to-unsafe-wash-services-\(per-100-000-population\)-\(sdg-3-9-2\)\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/mortality-rate-attributed-to-exposure-to-unsafe-wash-services-(per-100-000-population)-(sdg-3-9-2)))).

### 3.a.1 Prevalence of current tobacco use among persons aged 15 years and older

- WHO Global Tobacco Control Policy Data: (<https://www.who.int/publications/i/item/WHO-HEP-HPR-TFI-2021.10>, accessed 16 August 2023).

### 3.b.1 Coverage of diphtheria-tetanus-pertussis (DTP3) vaccination

- WHO immunization data portal: (<https://immunizationdata.who.int>, accessed 16 August 2023).

### 3.b.1 Coverage of measles-containing-vaccine second-dose (MCV2)

- WHO immunization data portal: (<https://immunizationdata.who.int>, accessed 16 August 2023).

### 3.b.1 Coverage of pneumococcal conjugate 3rd dose (PCV3) vaccination

- WHO immunization data portal: (<https://immunizationdata.who.int>, accessed 16 August 2023).

### 3.b.2 Total official development assistance to medical research and basic health sectors, by recipient countries

- The Global Health Observatory [online database]. Geneva: World Health Organization (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/total-net-official-development-assistance-to-medical-research-and-basic-health-sectors-per-capita>)

### 3.b.3 Availability of selected essential medicines in public health facilities

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/Indicator/TermID/85>, accessed 16 August 2023).

### 3.c.1 Density of physicians per 10 000 population

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/Indicator/TermID/71>, accessed 16 August 2023).

### 3.c.1 Density of nurses and midwives per 10 000 population

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/Indicator/TermID/72>, accessed 16 August 2023).

### 3.c.1 Density of pharmacists per 10 000 population

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/Indicator/TermID/74>, accessed 16 August 2023).

### 3.c.1 Density of dentists per 10 000 population

- Eastern Mediterranean Health Observatory [online database]. Cairo: WHO Regional Office for the Eastern Mediterranean (<https://rho.emro.who.int/Indicator/TermID/73>, accessed 16 August 2023).

### 3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness index

- The Global Health Observatory [online database]. Geneva: World Health Organization (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/-average-of-13-international-health-regulations-core-capacity-scores-1st-version-of-the-questionnaire>).

### 3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms

- The Global Health Observatory [online database]. Geneva: World Health Organization (<https://www.who.int/data/gho/indicator-metadata-registry/imr-details/5751>, accessed 16 August 2023).

### 4.1.1 Proportion of children at the end of primary achieving at least a minimum proficiency level in reading

- SDG4 March 2023 Release [online database]. UNESCO Institute for Statistics Technical Cooperation Group. New York: (<http://sdg4-data.uis.unesco.org>, accessed 16 August 2023).

### 4.1.2 Primary education completion rate

- SDG4 March 2023 Release [online database]. UNESCO Institute for Statistics Technical Cooperation Group. New York: (<http://sdg4-data.uis.unesco.org>, accessed 16 August 2023).

### 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence

- The Global Health Observatory [online database]. Geneva: World Health Organization (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/proportion-of-ever-partnered-women-and-girls-aged-15-49-years-subjected-to-physical-and-or-sexual-violence-by-a-current-or-former-intimate-partner-in-the-previous-12-months>, accessed 16 August 2023).

### 5.6.1 Proportion of women aged 15–49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/proportion-of-women-aged-15-49-who-make-their-own-informed-decisions-regarding-sexual-relations-contraceptive-use-and-reproductive-health-care-\(sdg-5.6.1\)](https://www.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/proportion-of-women-aged-15-49-who-make-their-own-informed-decisions-regarding-sexual-relations-contraceptive-use-and-reproductive-health-care-(sdg-5.6.1)), accessed 16 August 2023).



### 6.1.1 Proportion of population with access to improved drinking-water services

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-using-safely-managed-drinking-water-services-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-using-safely-managed-drinking-water-services-(-)), accessed 16 August 2023).

### 6.2.1 Proportion of population with access to improved sanitation facilities

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-using-safely-managed-sanitation-services-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-using-safely-managed-sanitation-services-(-)), accessed 16 August 2023).

### 8.5.2 Unemployment rate

- ILOSTAT explorer [online database]. New York: International Labour Organization ([https://www.ilo.org/shinyapps/bulkexplorer20/?lang=en&segment=indicator&id=UNE\\_DEAP\\_SEX\\_AGE\\_RT\\_A](https://www.ilo.org/shinyapps/bulkexplorer20/?lang=en&segment=indicator&id=UNE_DEAP_SEX_AGE_RT_A), accessed 16 August 2023).

### 11.6.2 Annual mean levels of fine particulate matter in cities

- The Global Health Observatory [online database]. Geneva: World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/concentrations-of-fine-particulate-matter-\(pm2-5\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/concentrations-of-fine-particulate-matter-(pm2-5)), accessed 16 August 2023).

### 16.1.1 Homicides

- The Global Health Observatory [online database]. Geneva: World Health Organization (<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimates-of-rates-of-homicides-per-100-000-population>, accessed 16 August 2023).

### 16.2.1 Physical punishment/and or psychological aggression by caregivers

- UNICEF Data: Monitoring the situation of children and women [online database]. New York: United Nations, UNICEF (<https://data.unicef.org/topic/child-protection/violence/violent-discipline/>, accessed 16 August 2023).

## Annex 2

# SDG indicators and definitions

The Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development was developed by the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDGs) and agreed upon at the 48th session of the United Nations Statistical Commission held in March 2017.

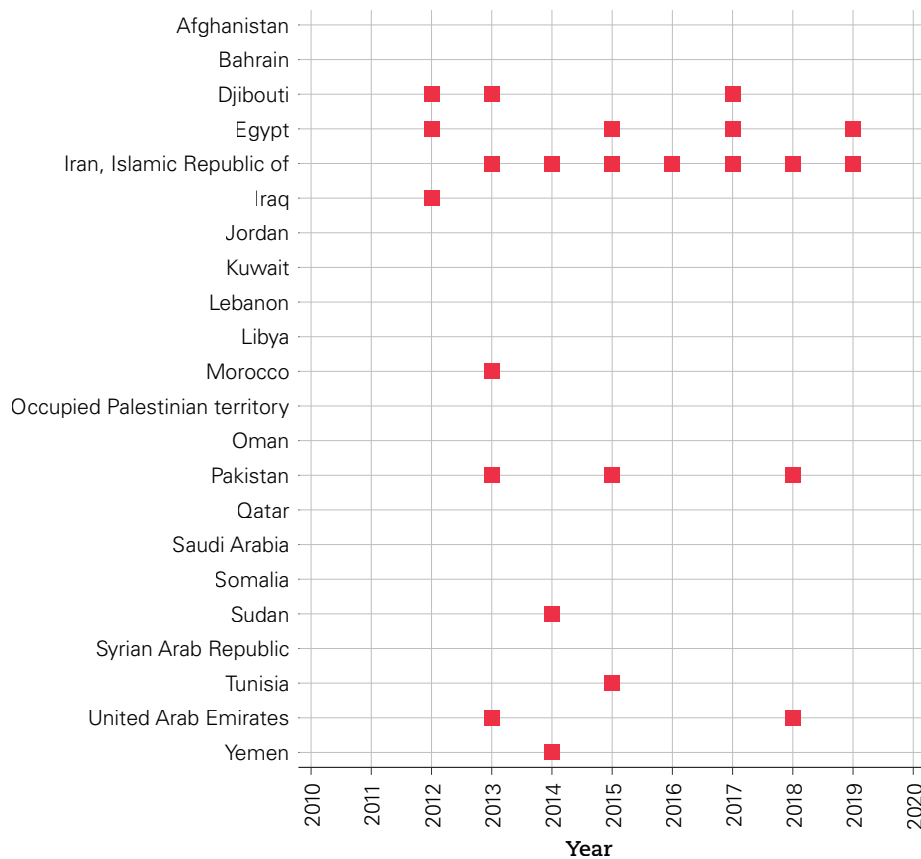
The detailed list is available at: [https://unstats.un.org/sdgs/indicators/Global%20Indicator%20Framework%20after%202020%20review\\_Eng.pdf](https://unstats.un.org/sdgs/indicators/Global%20Indicator%20Framework%20after%202020%20review_Eng.pdf)

The metadata (concepts, definitions and measurement) for the SDG indicators are available at <https://unstats.un.org/sdgs/metadata/> and reflect the latest reference metadata information provided by the United Nations system and other international organizations on data and statistics for the Tier I and II indicators (see: <https://unstats.un.org/sdgs/iaeg-sdgs/tier-classification/>) in the global indicator framework.

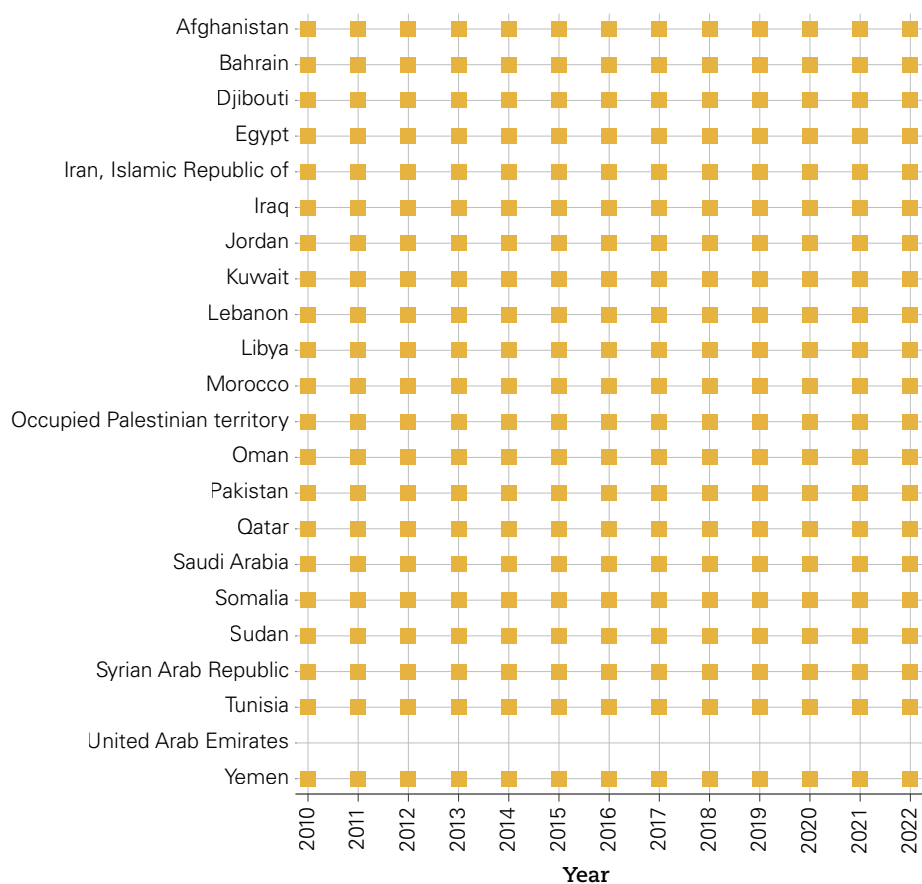
# Annex 3

## Data availability by selected SDG indicators by country

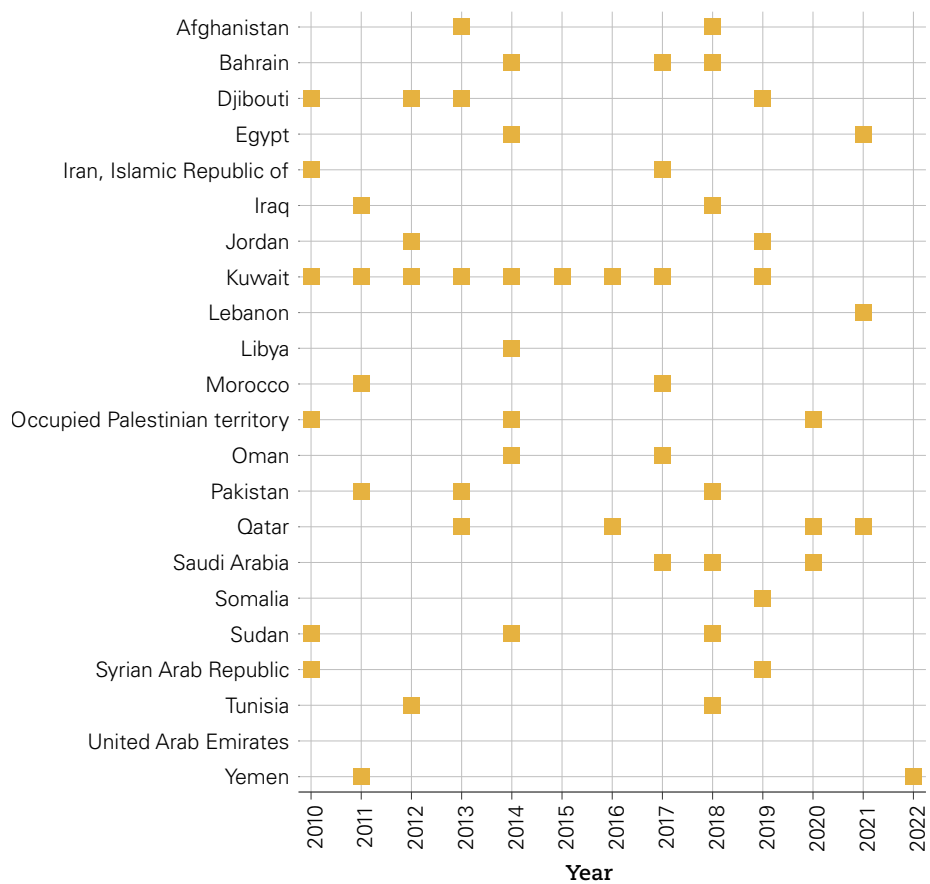
### 1.1.1 Proportion of population living below the international poverty line (%), 2010–2020



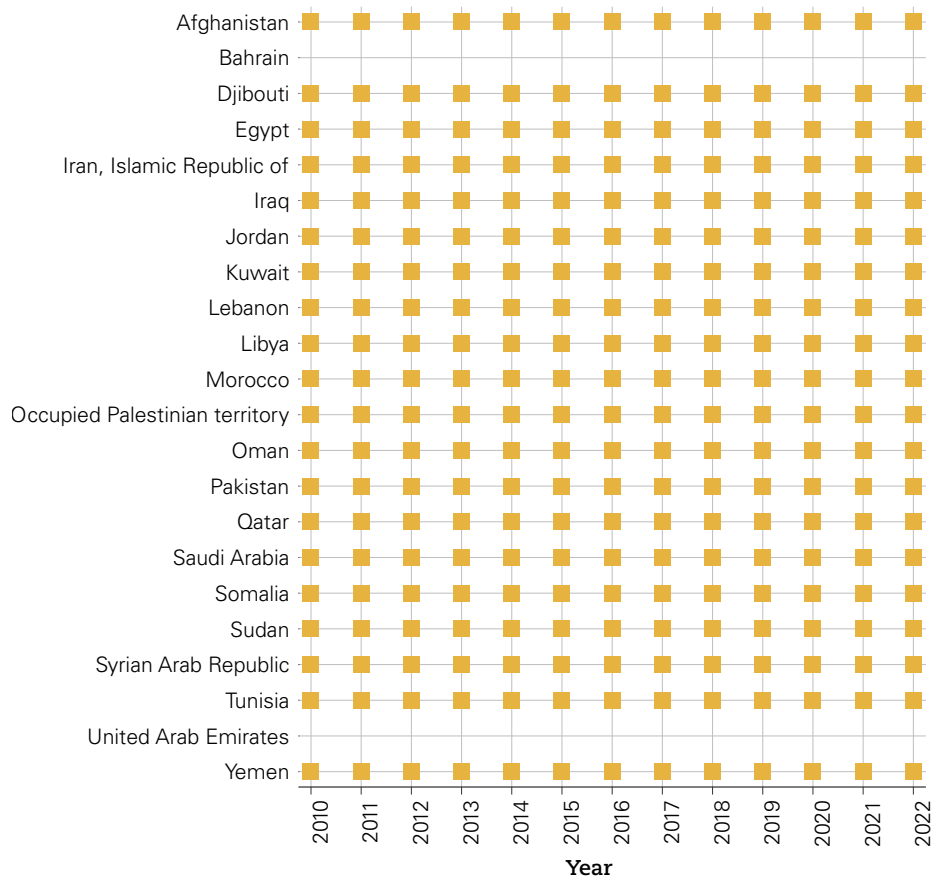
2.2.1 Stunting among children under 5, 2010–2022



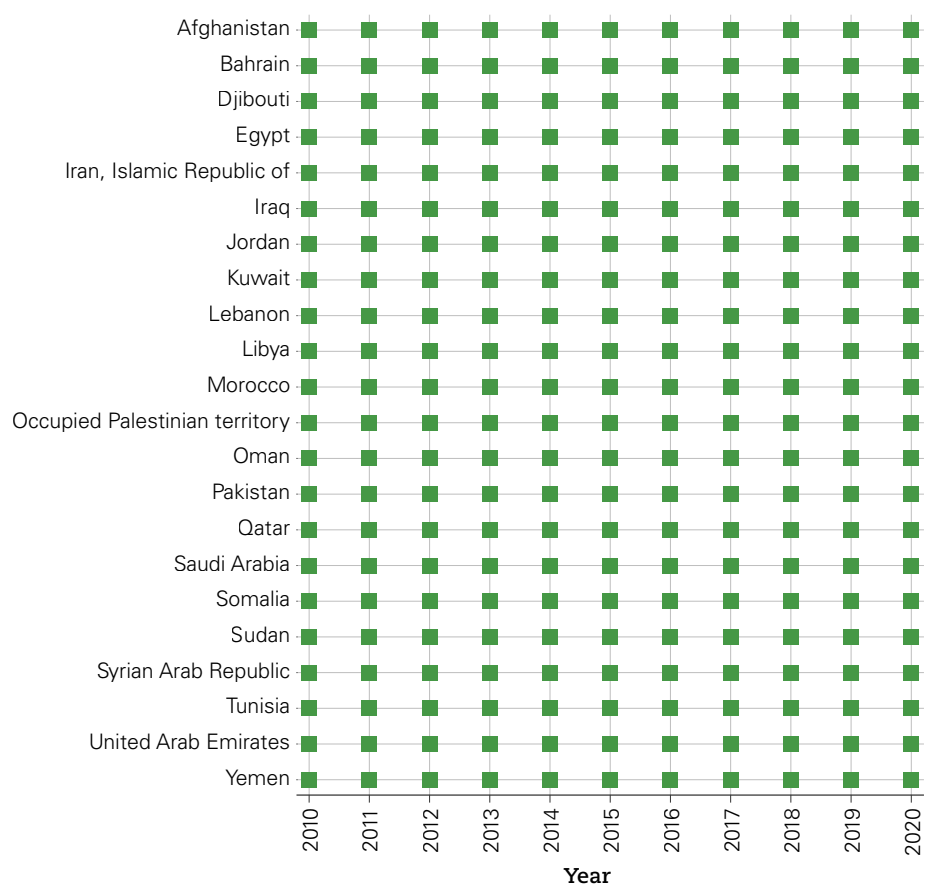
2.2.2 Wasting among children under 5, 2010–2022



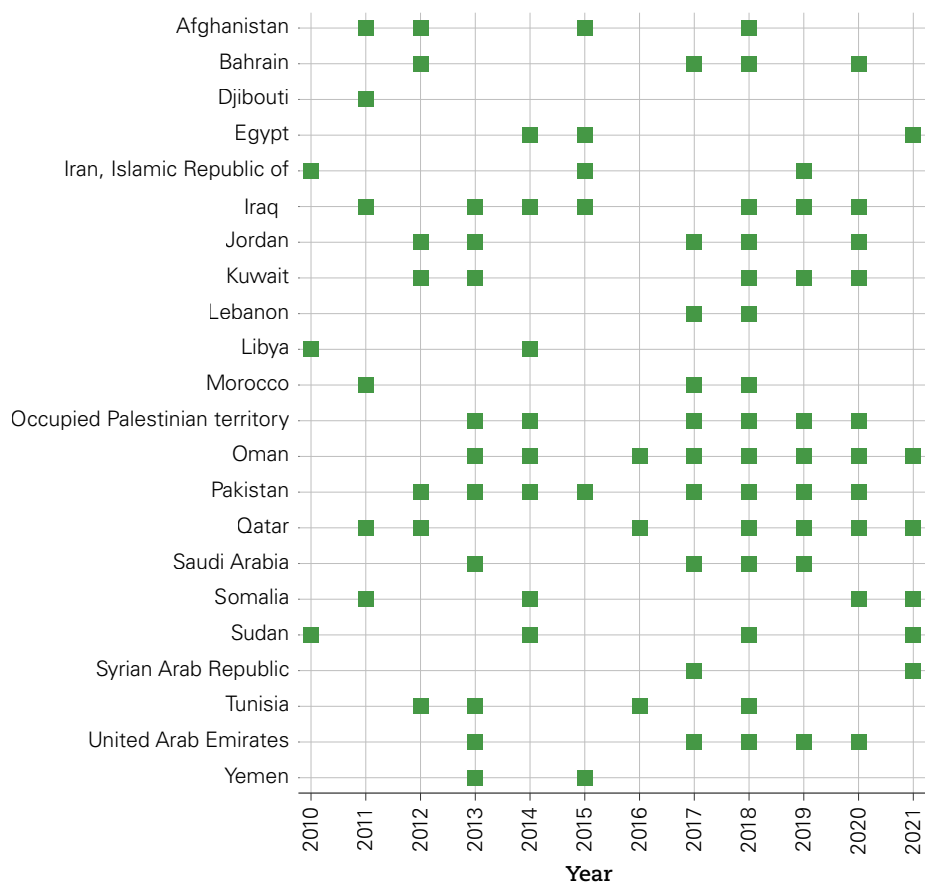
2.2.2 Overweight among children under 5, 2010–2022



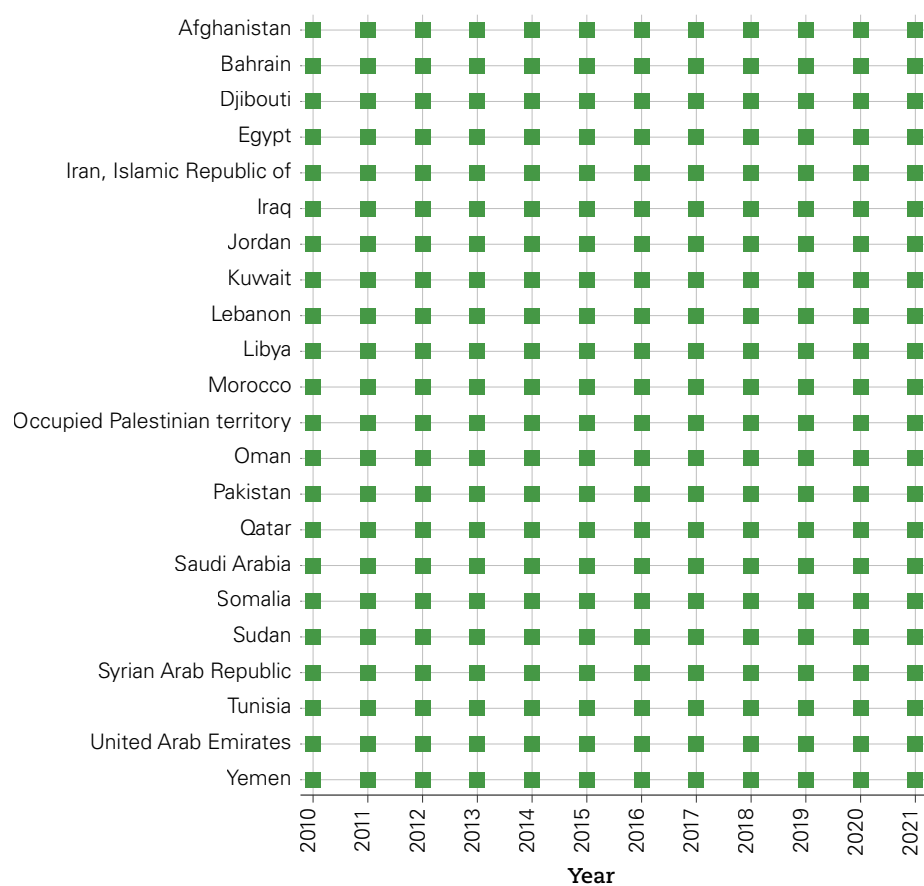
### 3.1.1 Maternal mortality ratio, 2010–2020



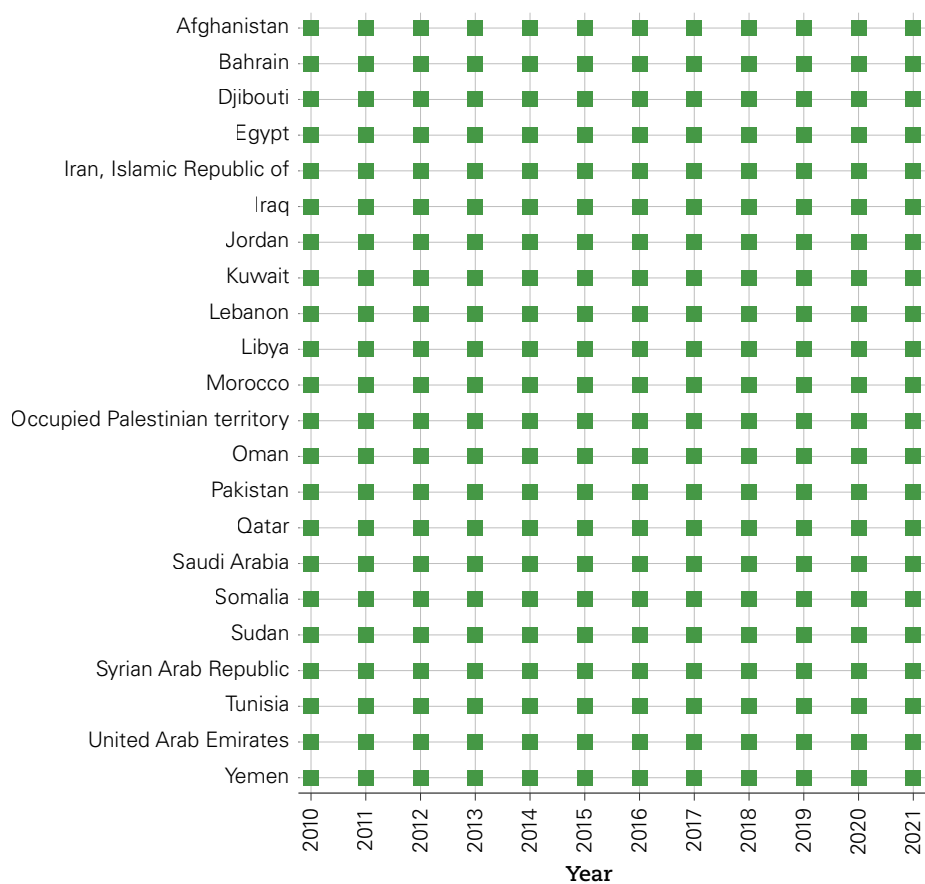
### 3.1.2 Births attended by skilled health personnel, 2010–2021



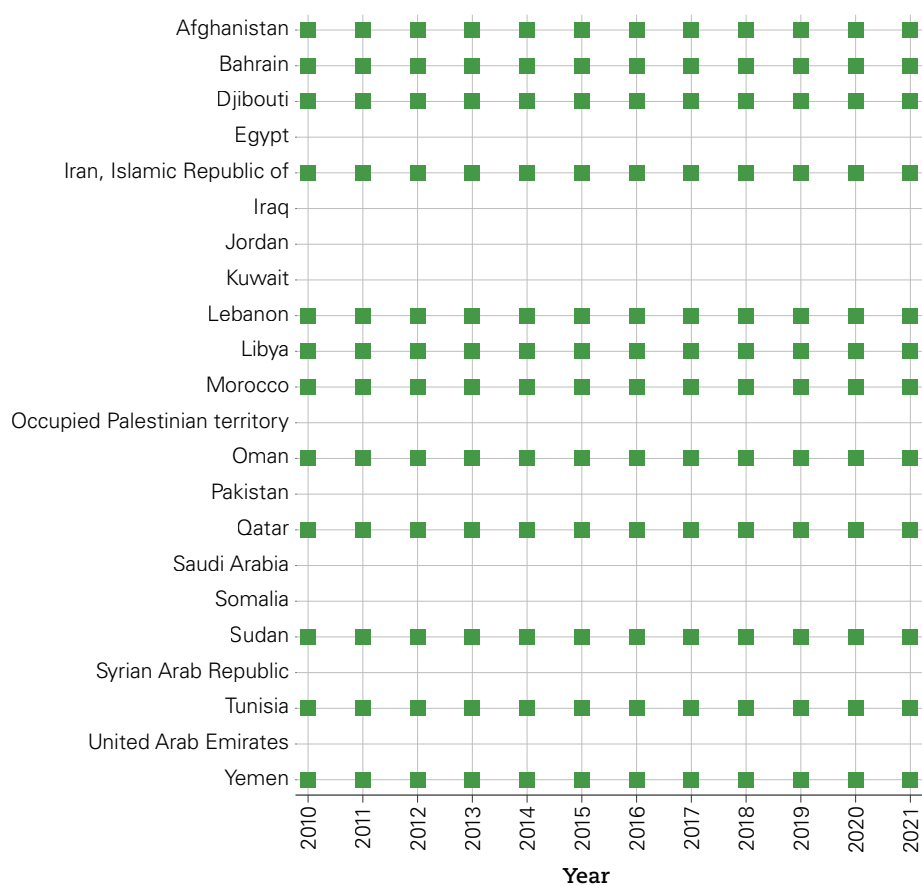


**3.2.1 Under-5 mortality rate, 2010–2021**

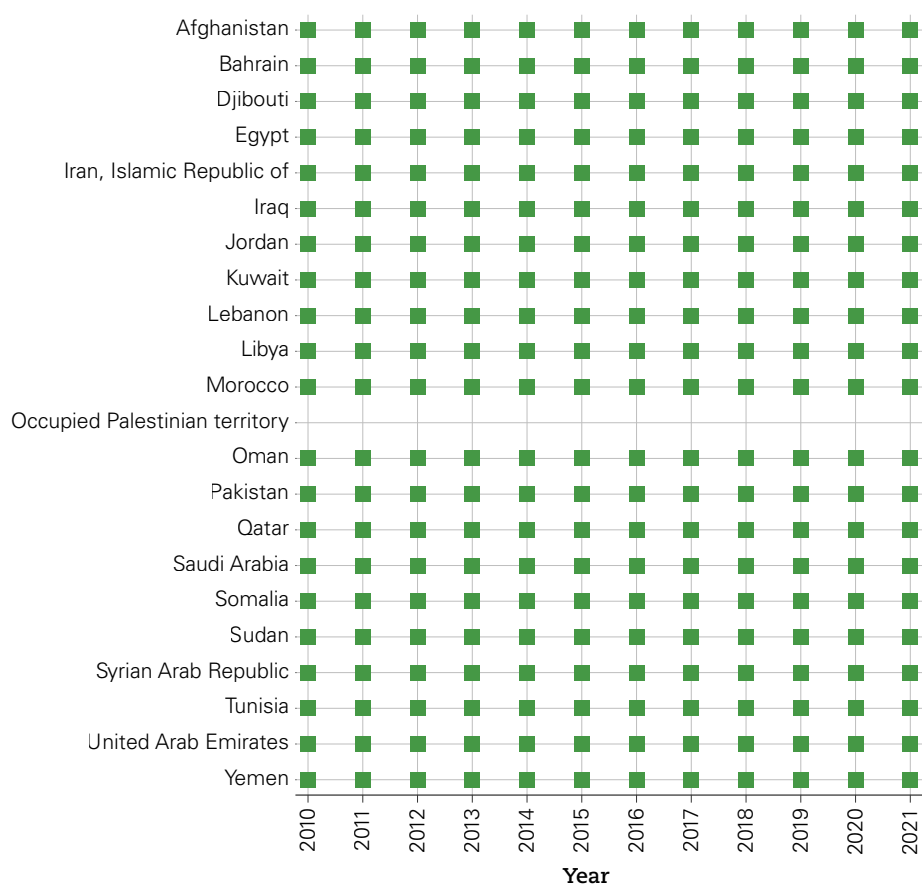
### 3.2.2 Neonatal mortality rate, 2010–2021



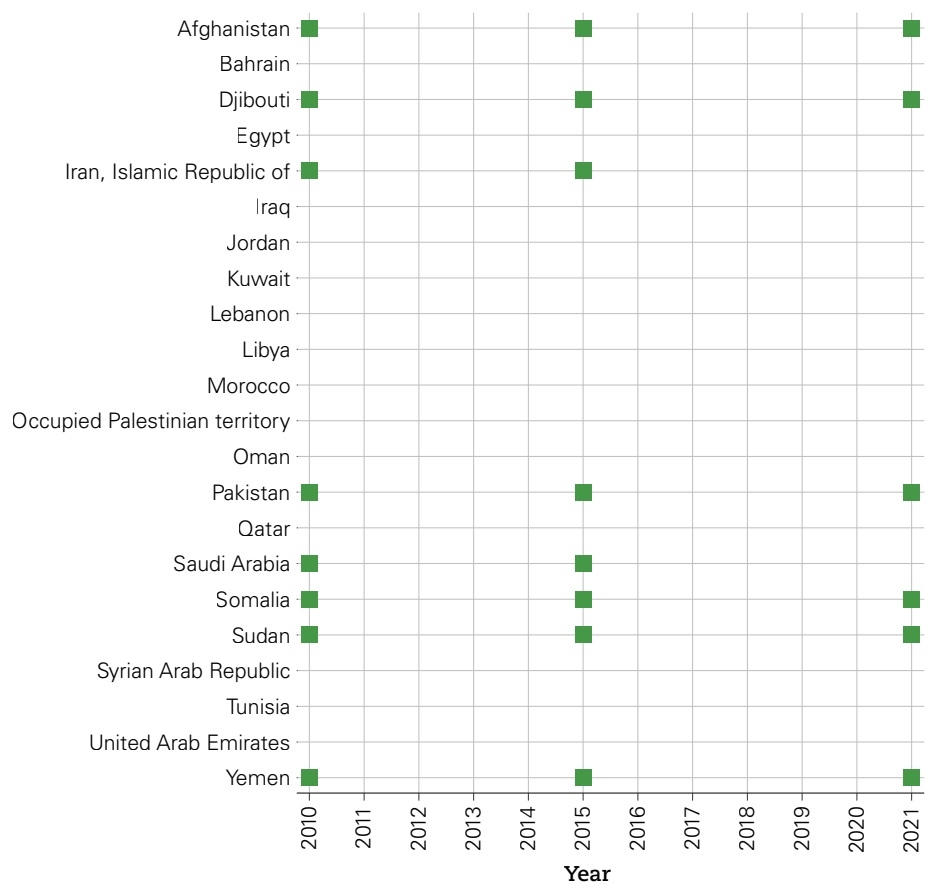
### 3.3.1 Number of new HIV infections (per 1000 uninfected population), 2010–2021



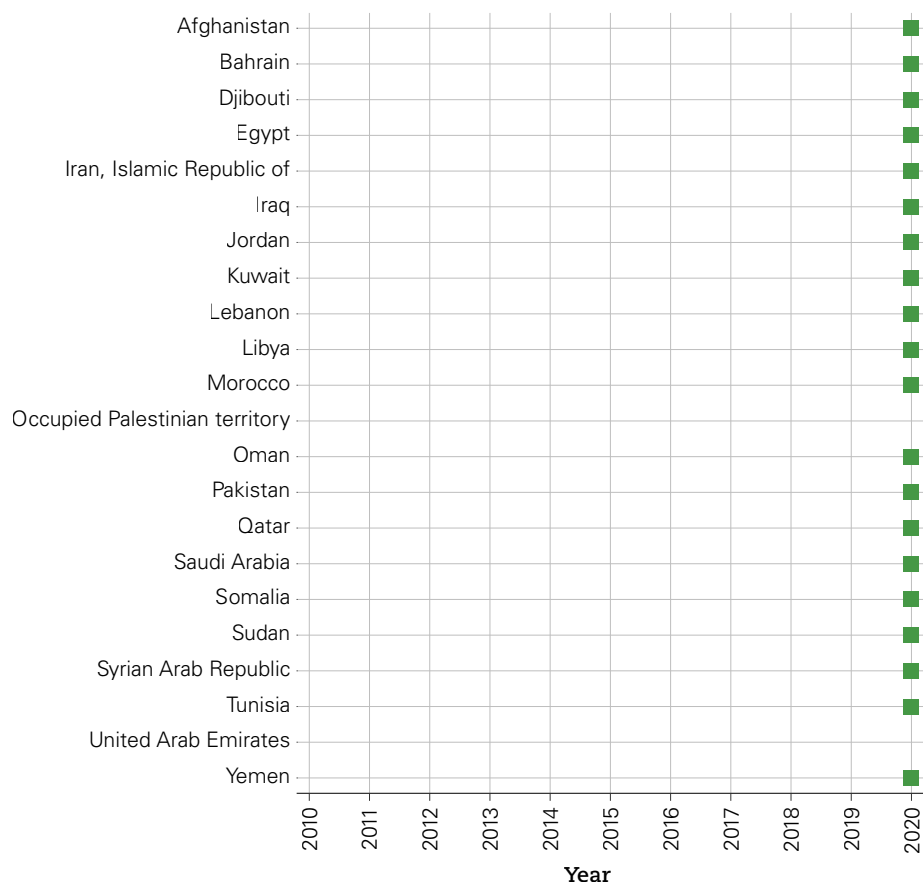
### 3.3.2 Tuberculosis incidence per 100 000 population, 2010–2021



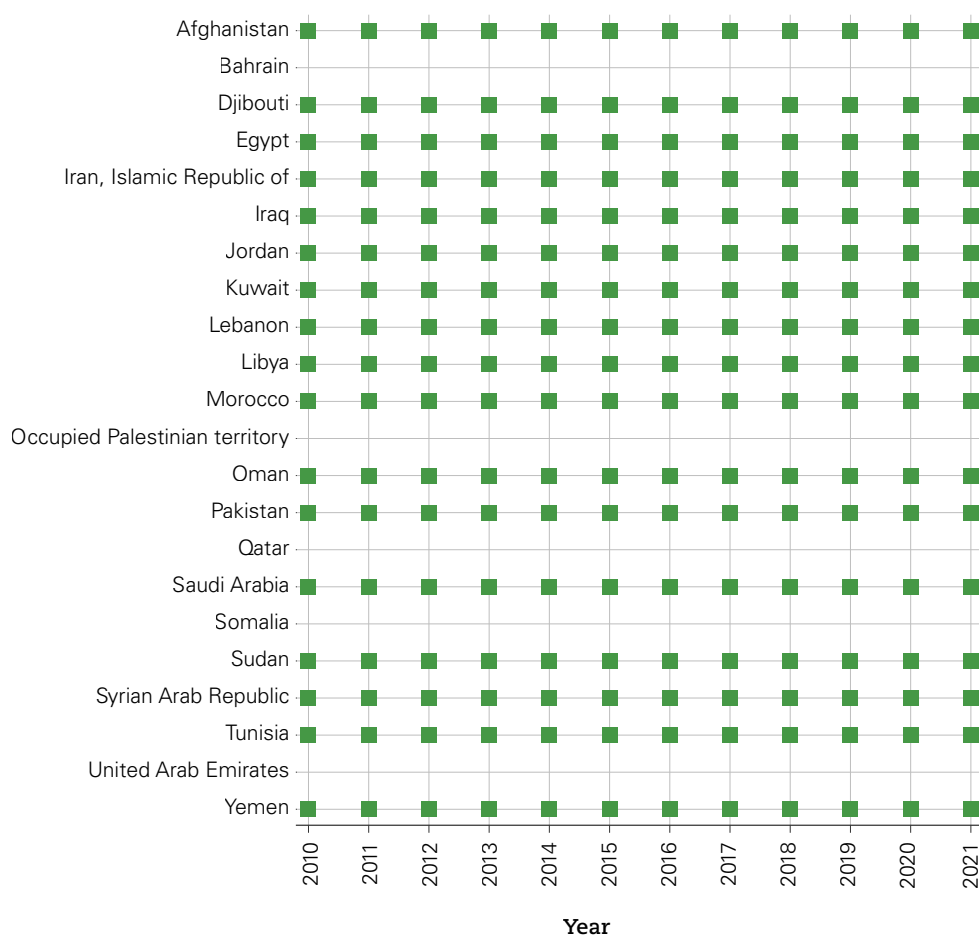
### 3.3.3 Malaria incidence per 100 000 population, 2010–2021



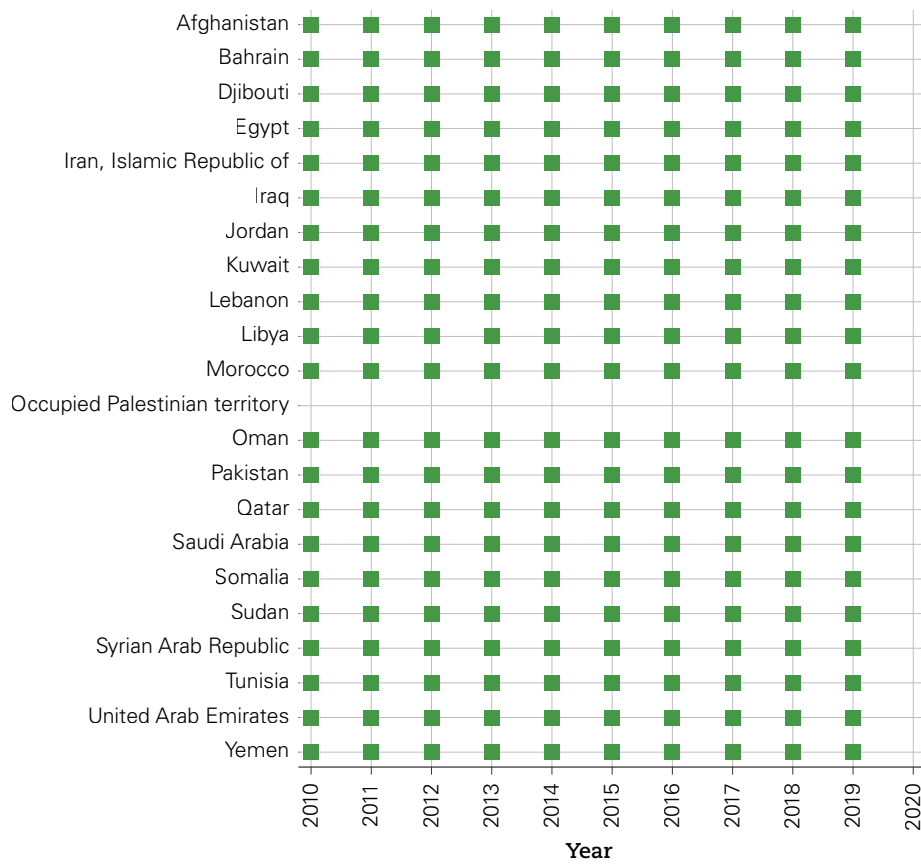
### 3.3.4 Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years, 2010–2020



### 3.3.5 Number of people requiring interventions against leishmaniasis, 2010–2021

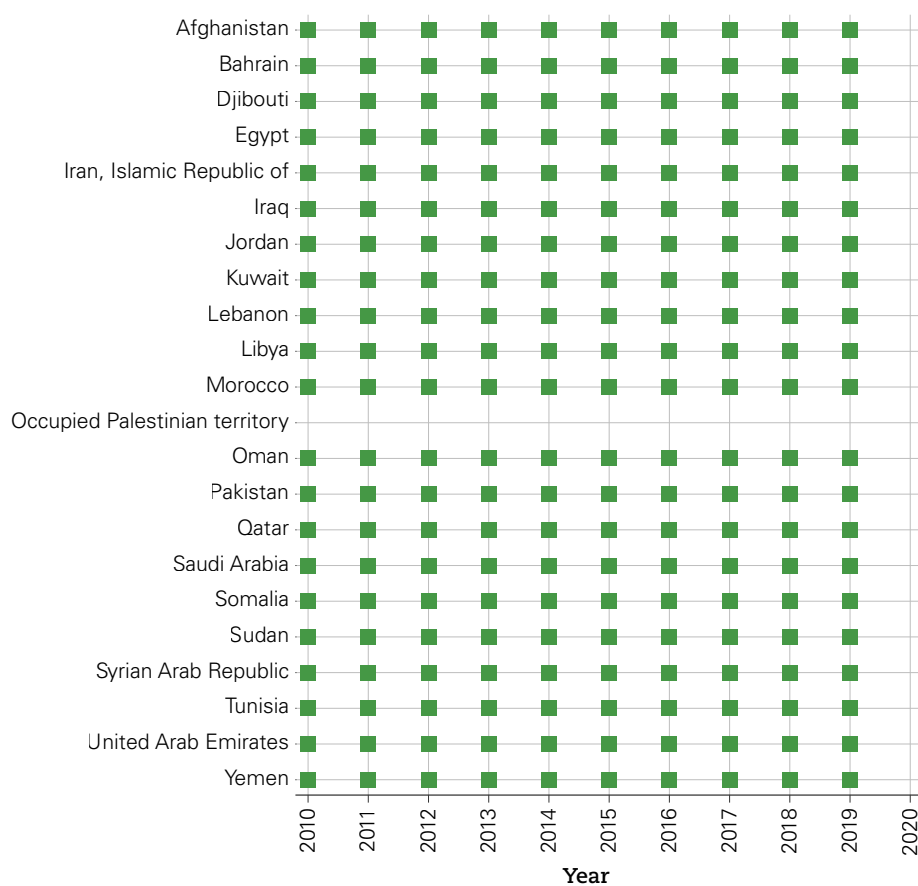


**3.4.1** Probability of dying from any cardiovascular disease, cancer, diabetes, chronic respiratory diseases between age 30 and exact age 70, 2010–2020

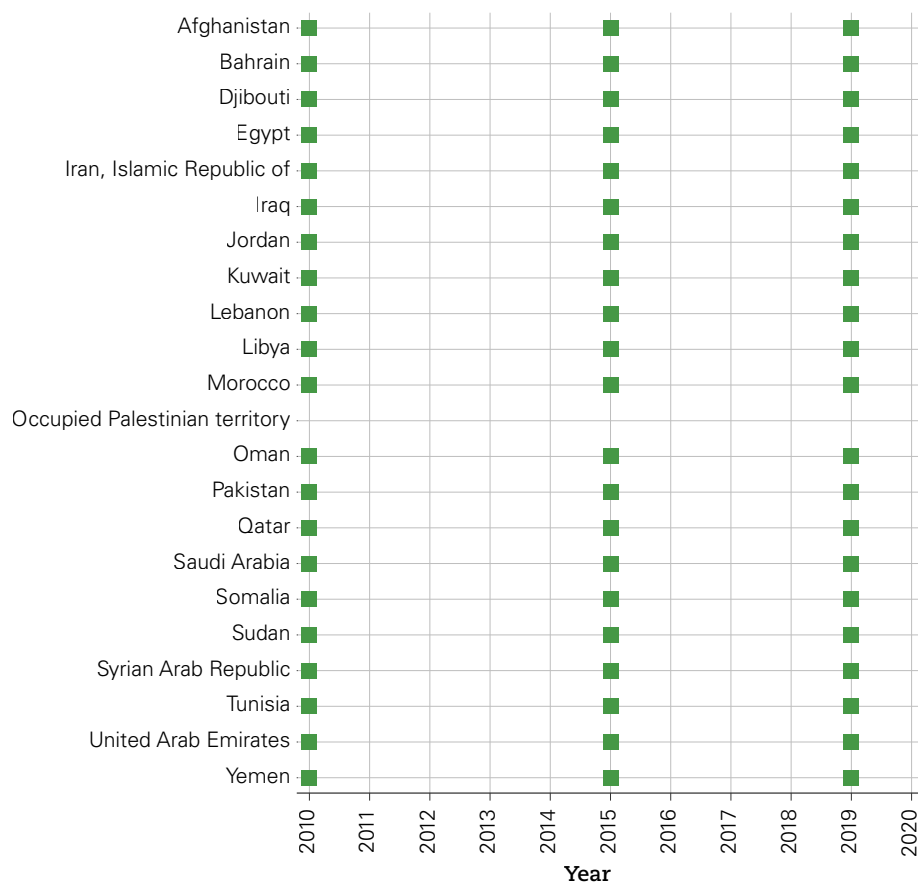




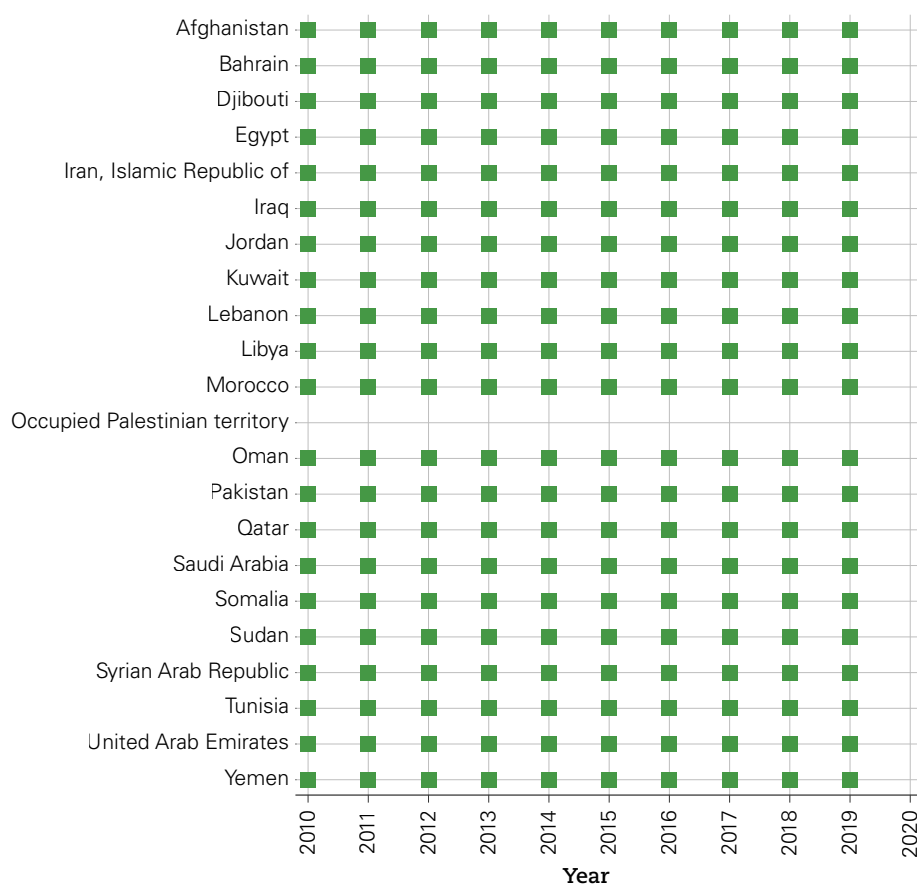
### 3.4.2 Suicide mortality rate, 2010–2020



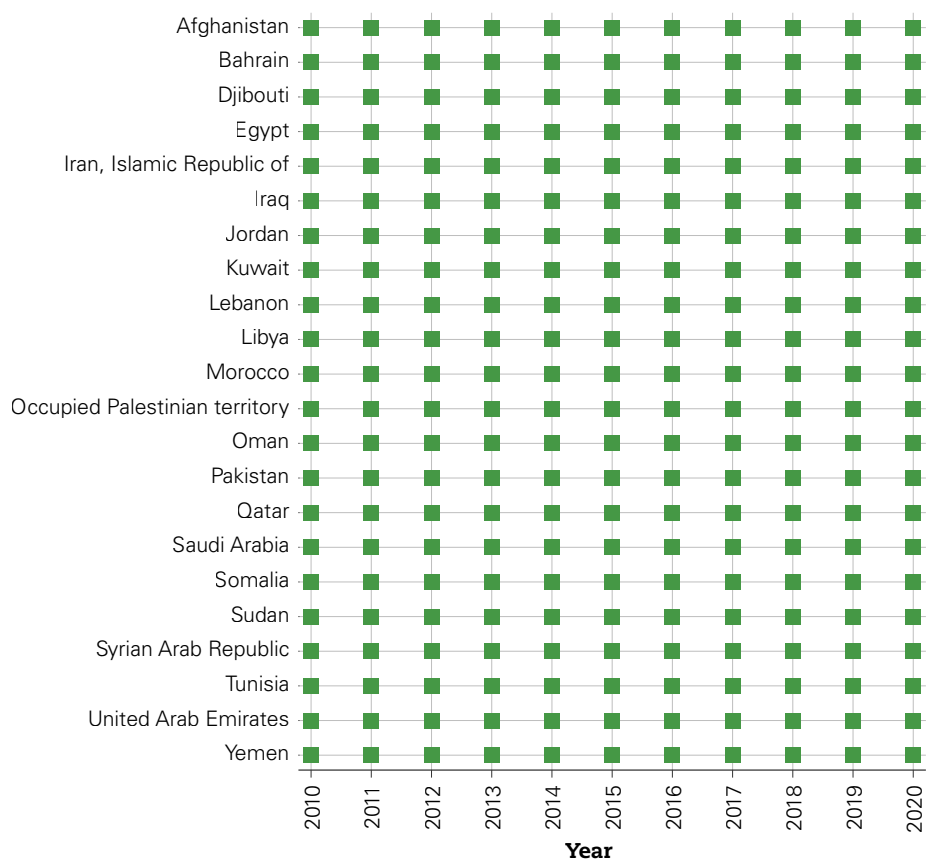
### 3.5.2 Harmful alcohol use, 2010–2020



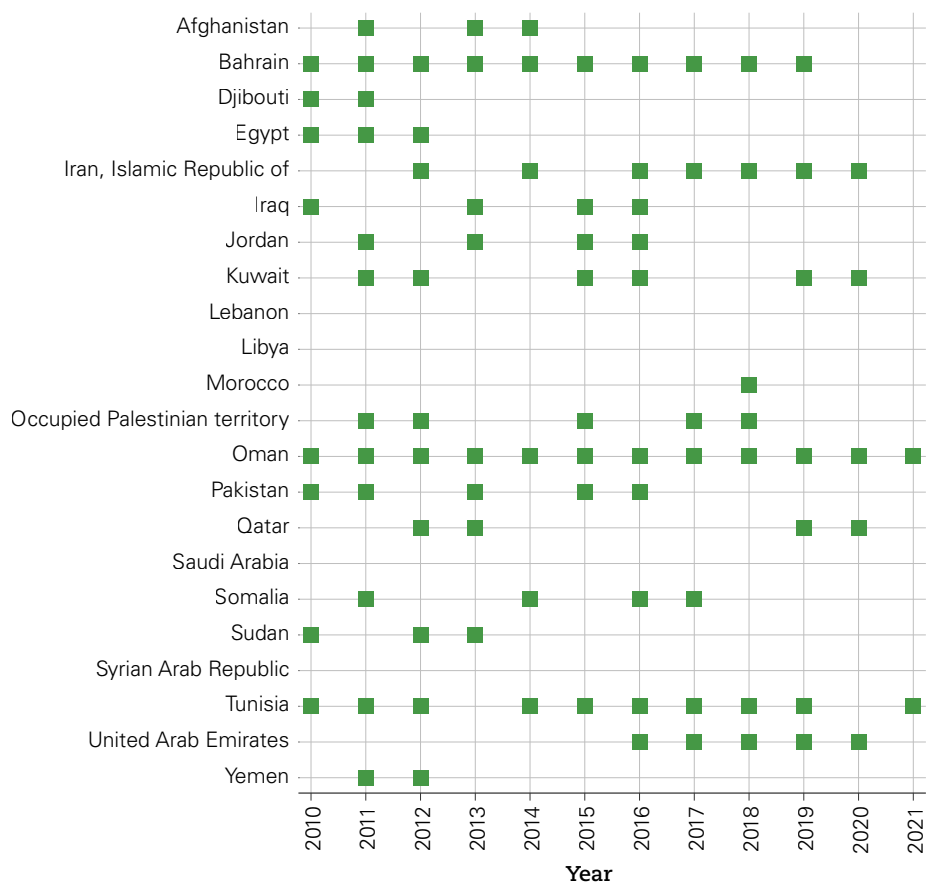
### 3.6.1 Mortality rate from road traffic injuries, 2010–2020



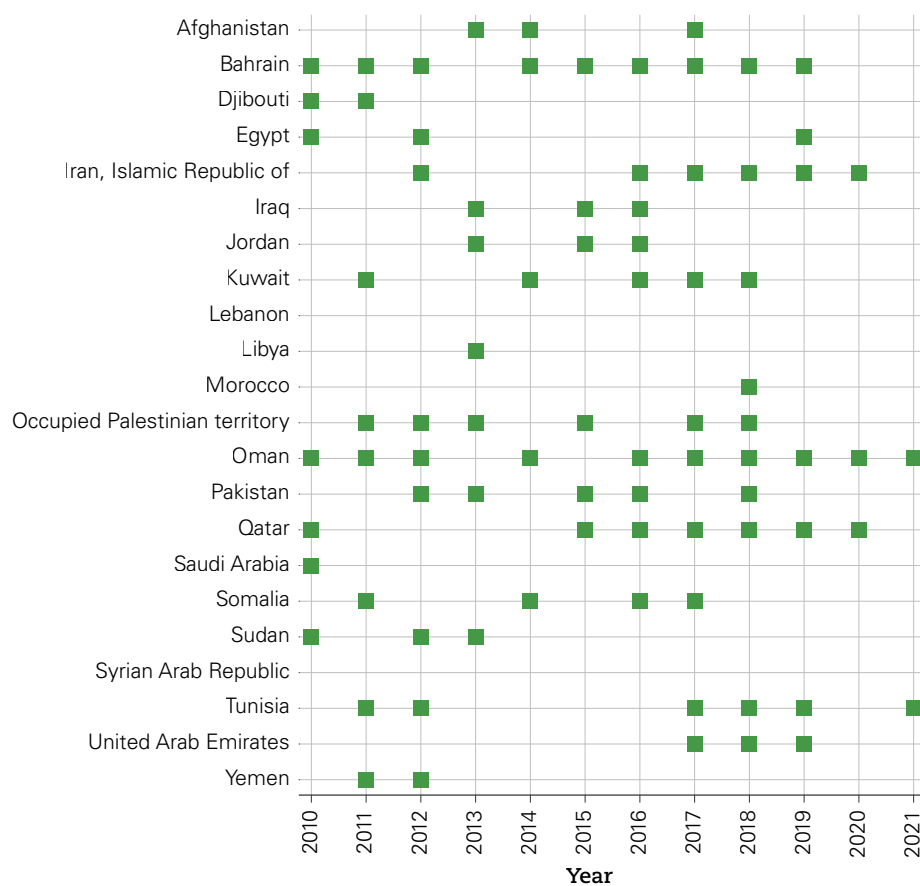
**3.7.1 Women of reproductive age (15–49) who had their need for family planning satisfied with modern methods, 2010–2020**



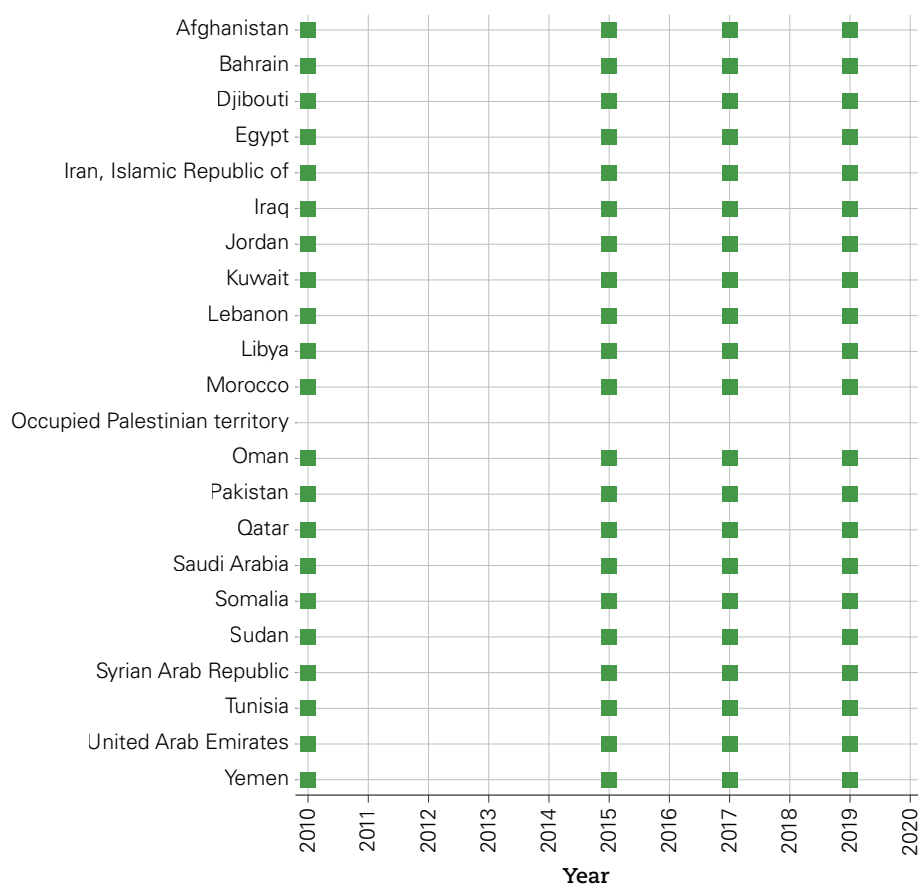
3.7.2 Adolescent birth rate (aged 10–14 years) per 1000 women, 2010–2021



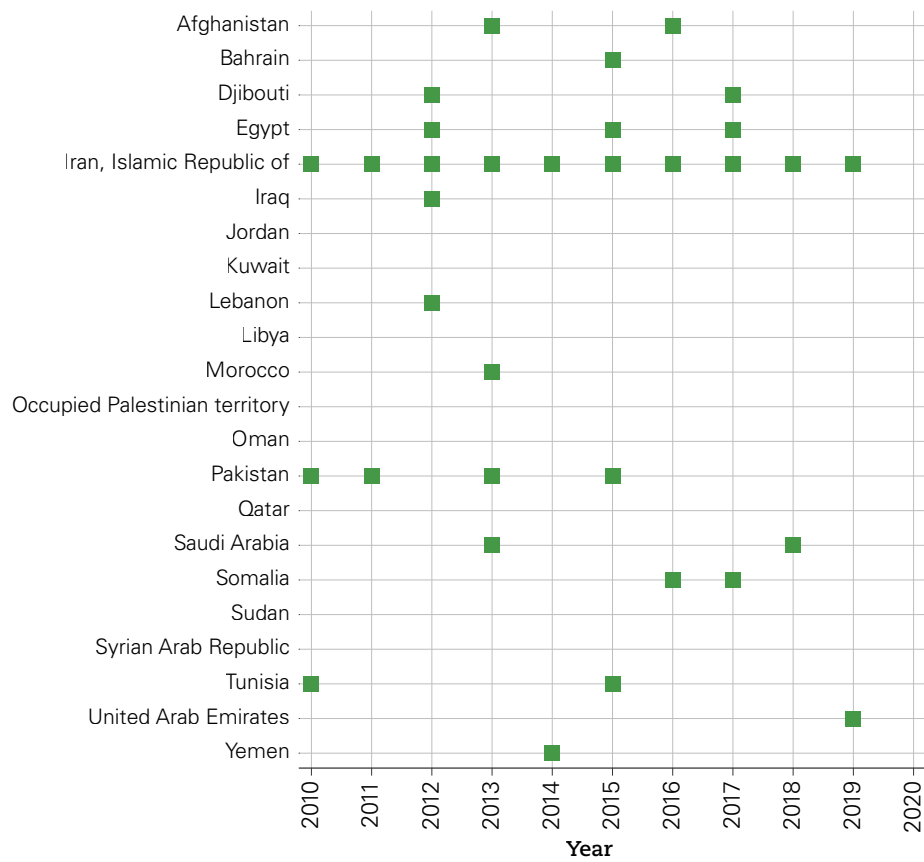
### 3.7.2 Adolescent birth rate (aged 15–19 years) per 1000 women, 2010–2020



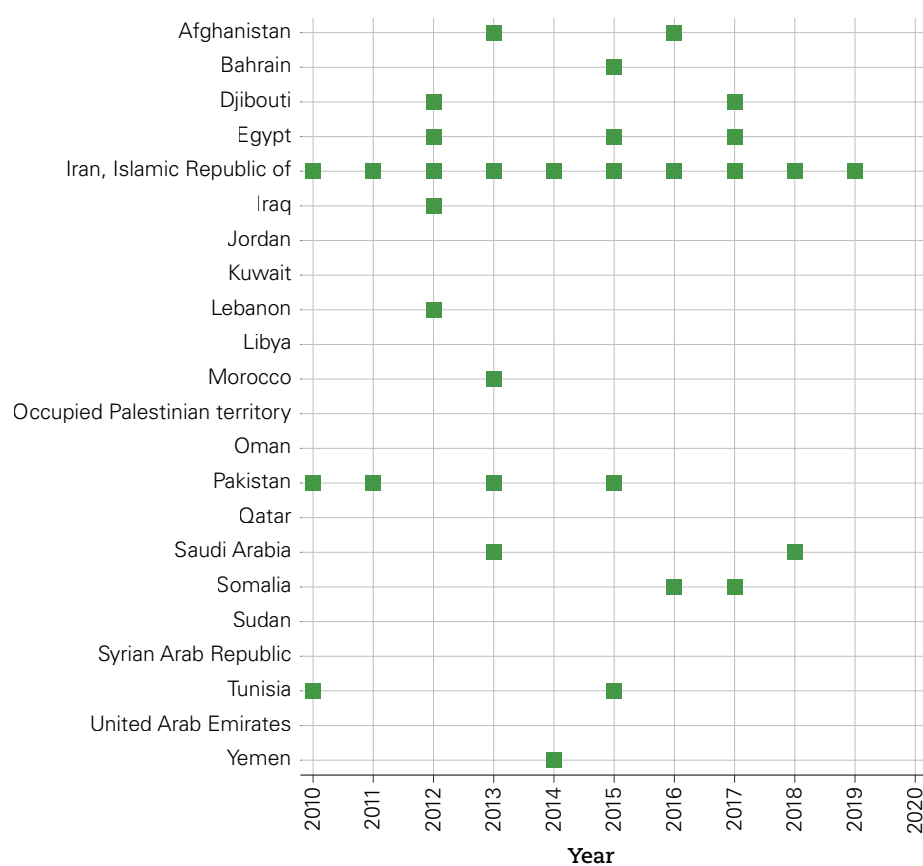
3.8.1 UHC service coverage index, 2010–2020



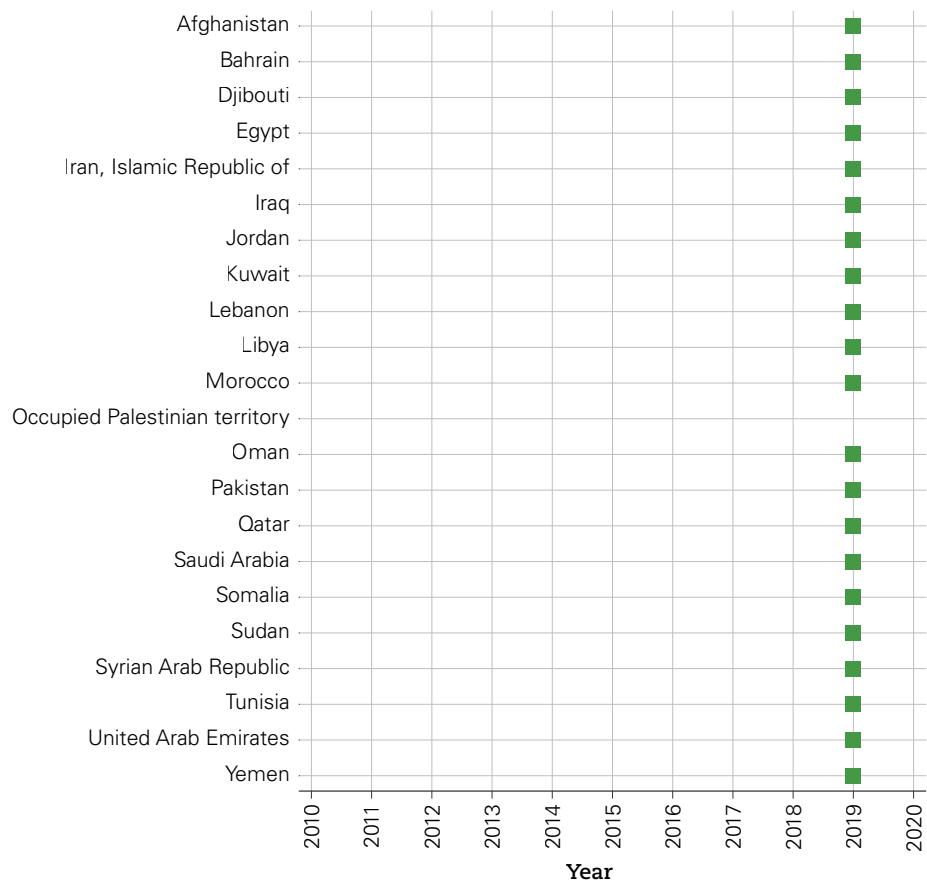
3.8.2 Large household expenditure as a share of total health care expenditure or income (>10%), 2010–2020

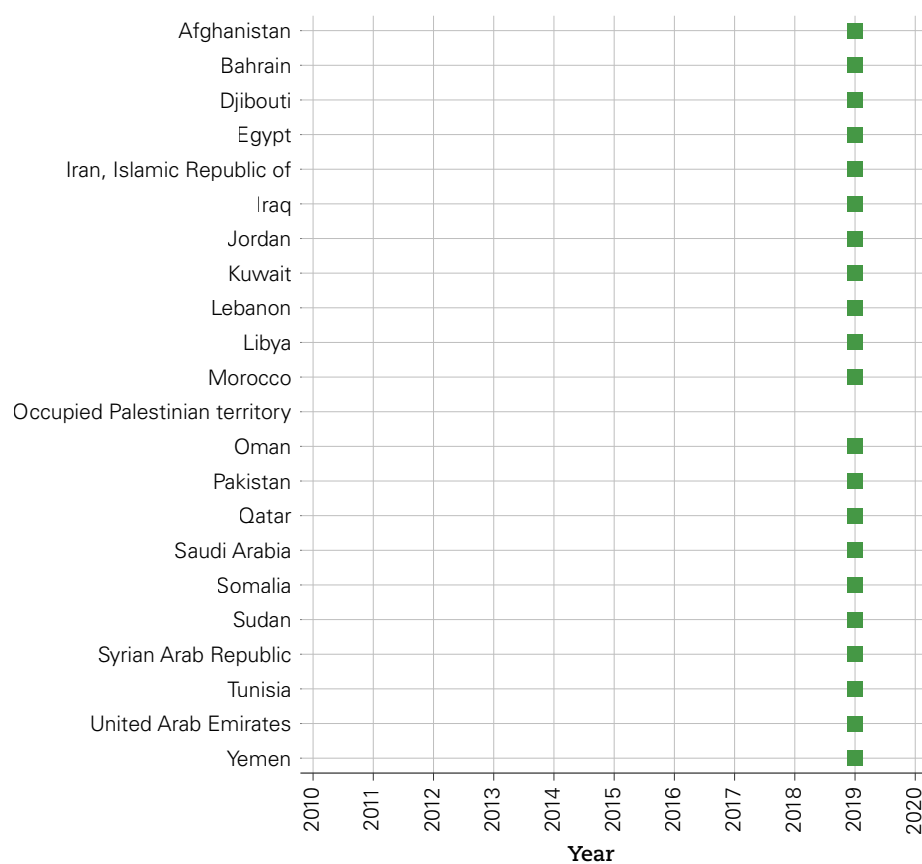




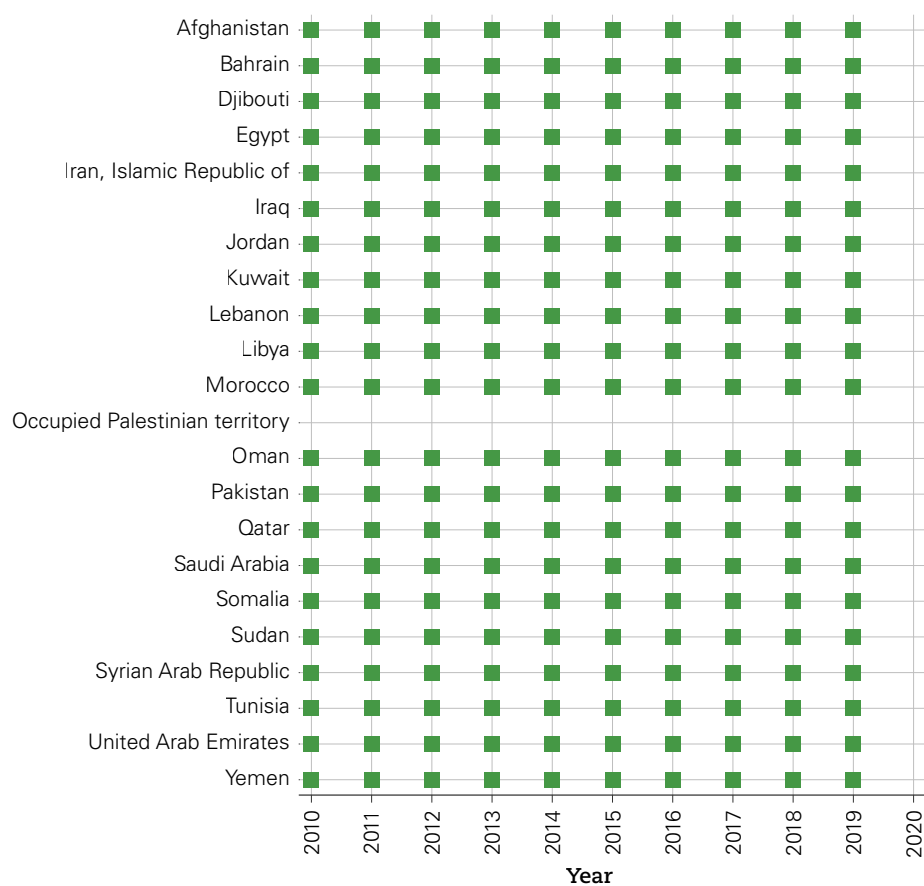
**3.8.2 Large household expenditure as a share of total health care expenditure or income (>25%), 2010–2020**

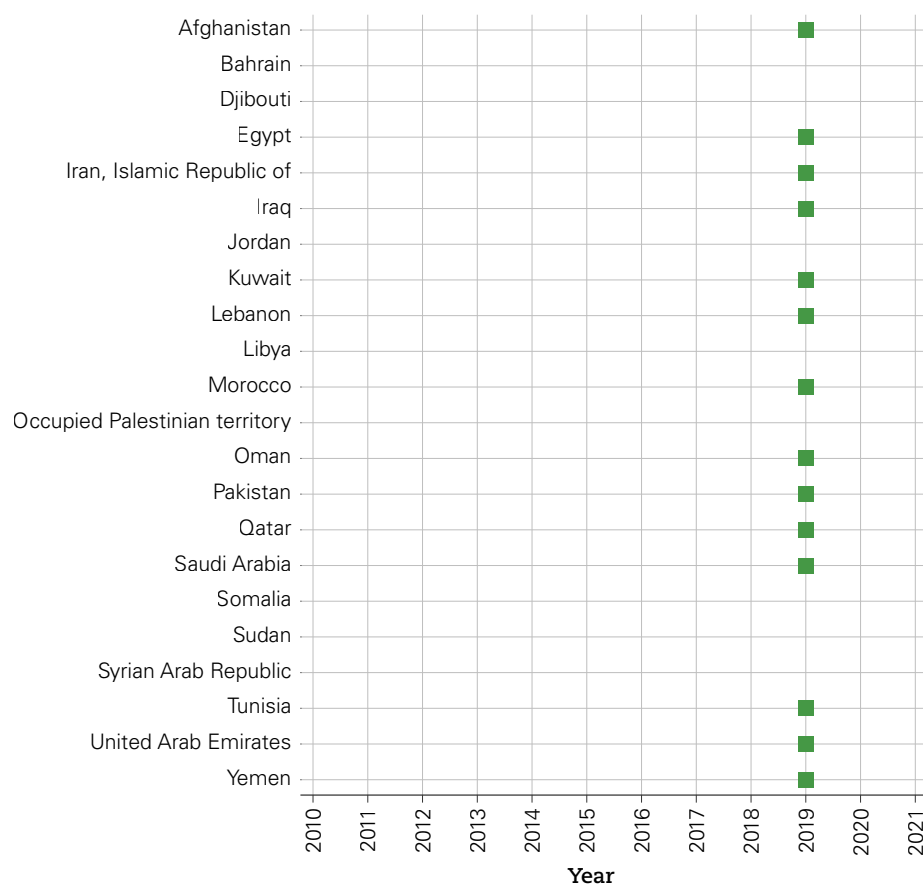
### 3.9.1 Mortality rate attributed to ambient and household air pollution, 2010–2020



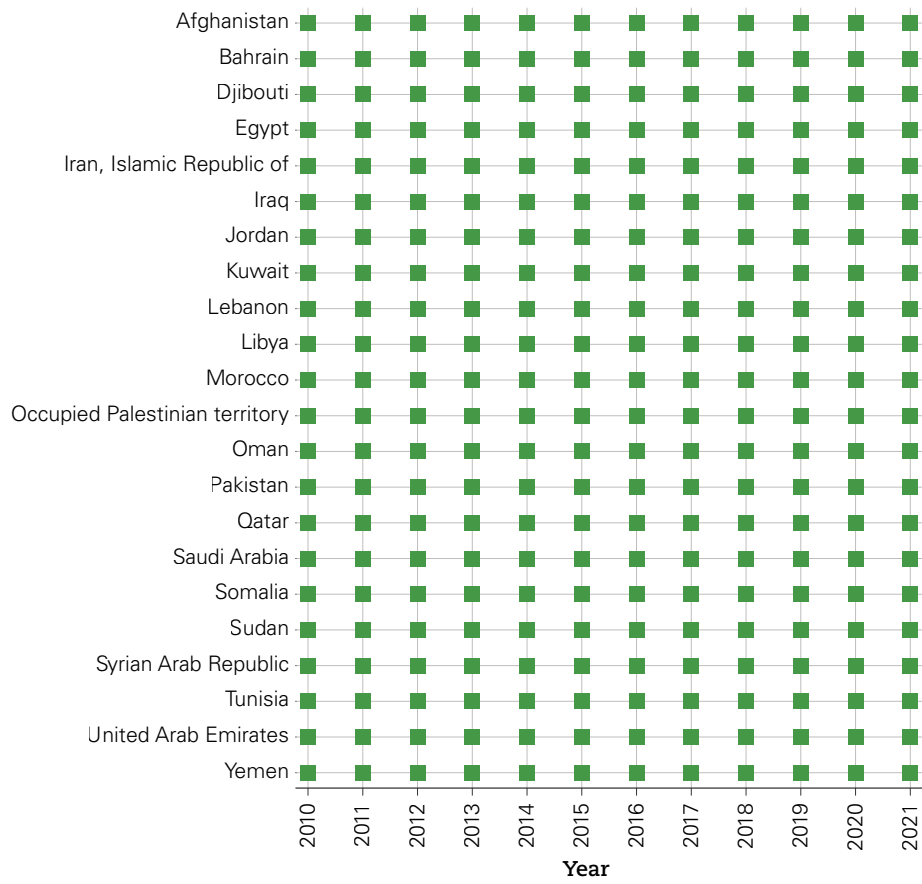
**3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene, 2010–2020**

### 3.9.3 Mortality rate attributed to unintentional poisoning, 2010–2020

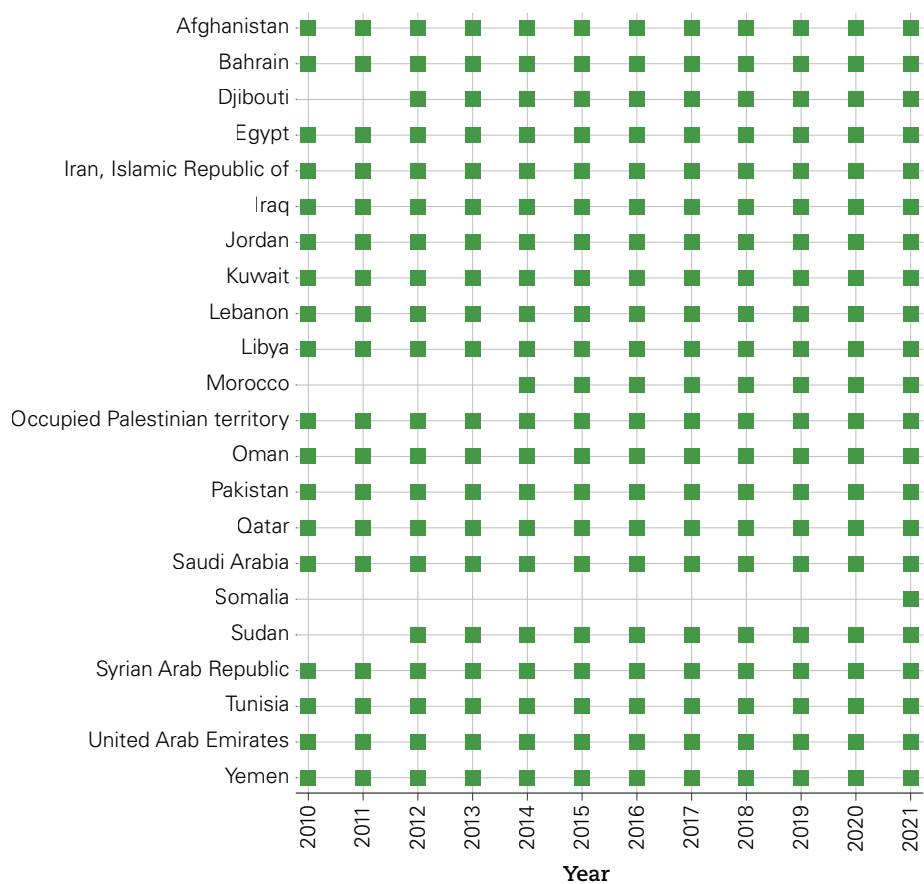


**3.a.1 Prevalence of tobacco use among persons 15 years and older, 2010–2021**

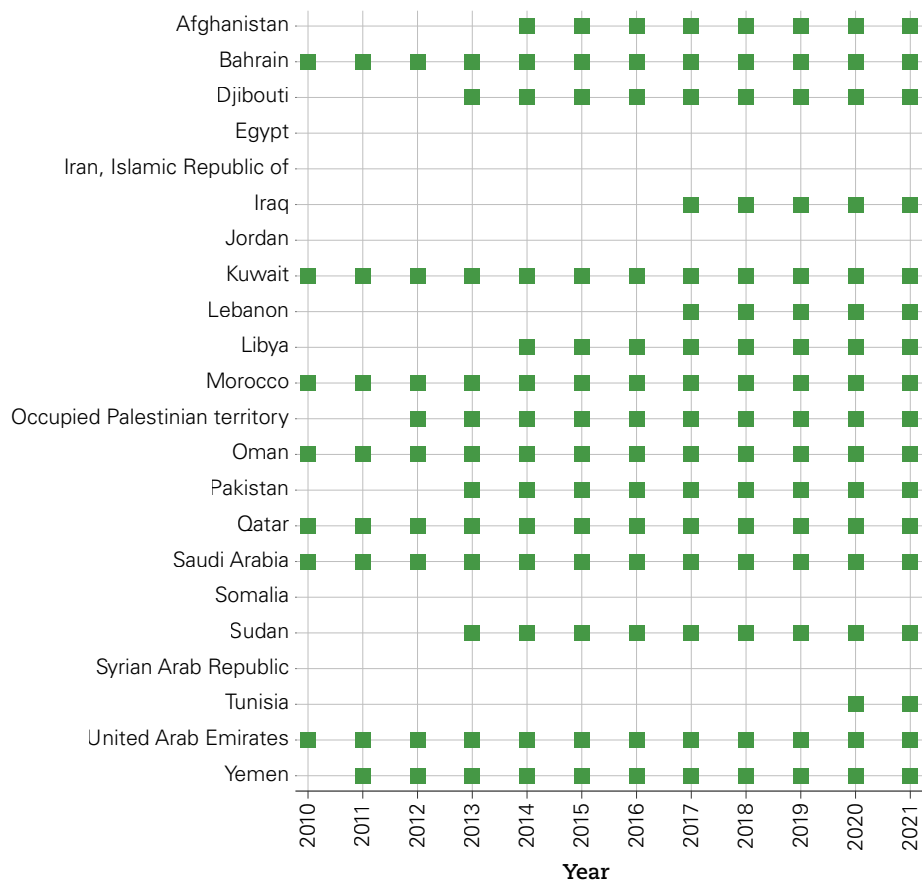
3.b.1 Coverage of DTP3 vaccination, 2010–2021



### 3.b.1 Coverage of MCV2 vaccination, 2010–2021



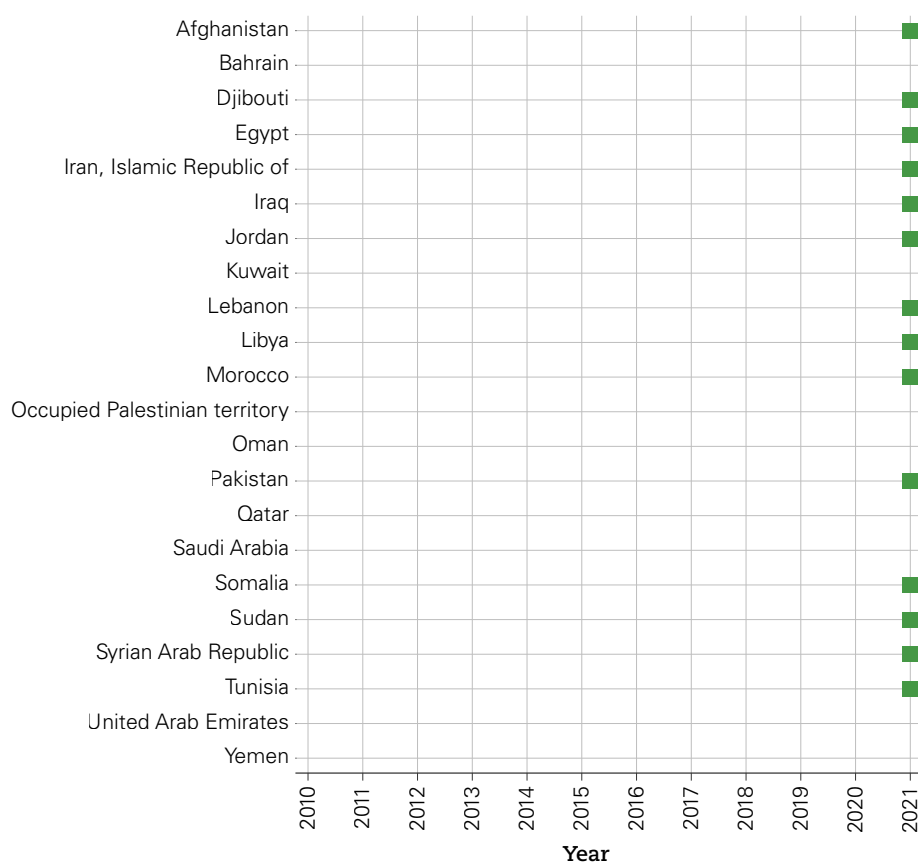
3.b.1 Coverage of PCV3 vaccination, 2010–2021



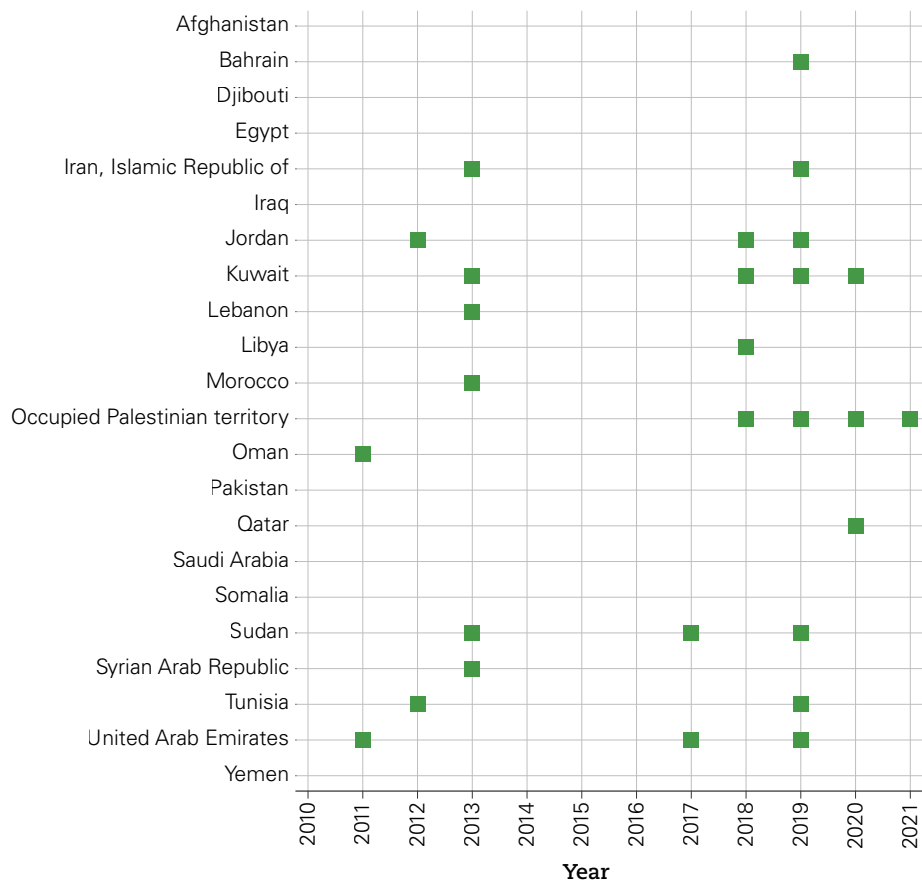


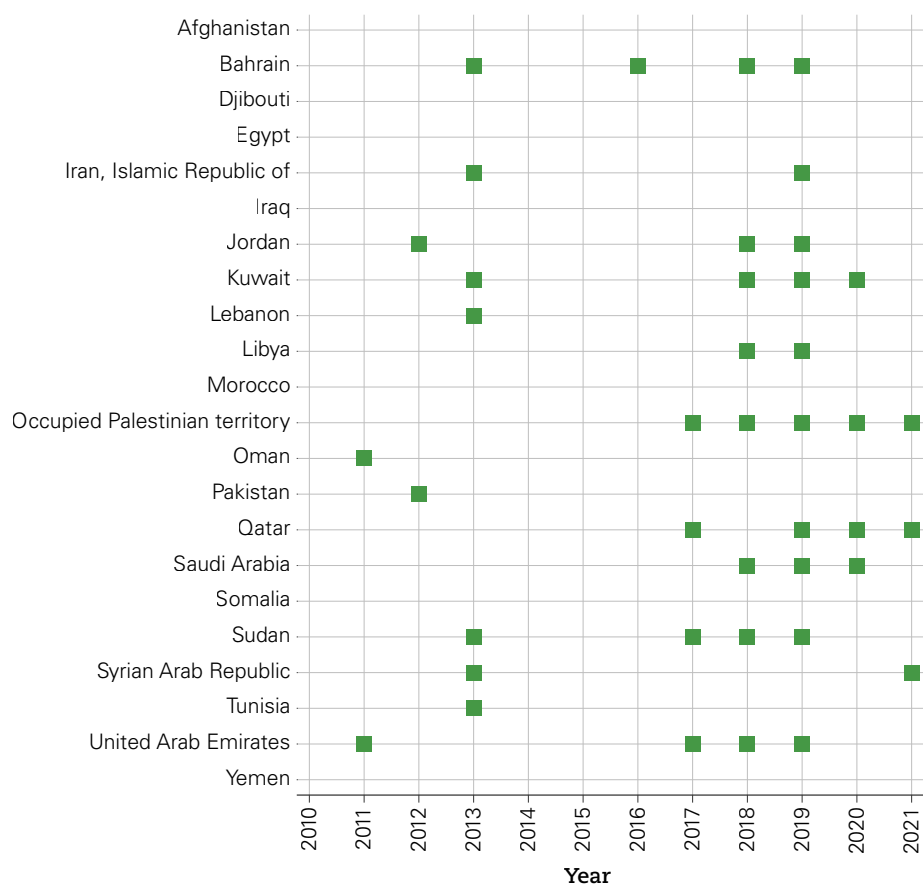
## 3.b.2

## Official development assistance (ODA) for medical research and basic health sectors per capita, by recipient country, 2010–2021

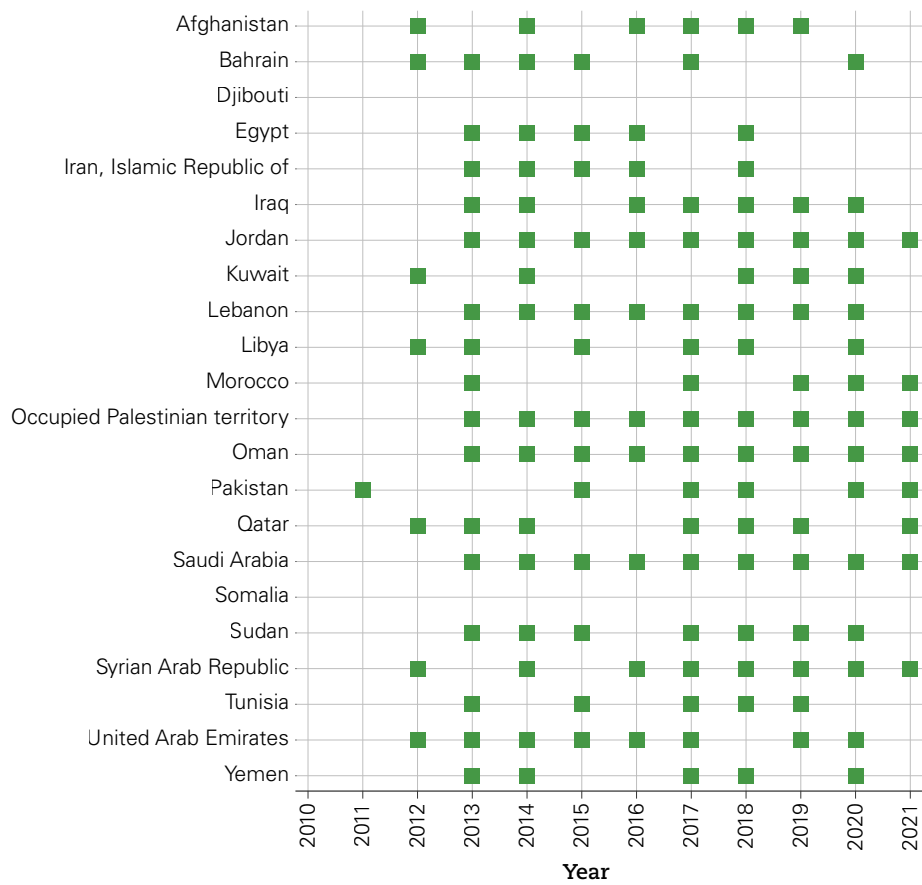


3.b.3 Availability of essential medicines in private health facilities, 2010–2021



**3.b.3 Availability of essential medicines in public health facilities, 2010–2021**

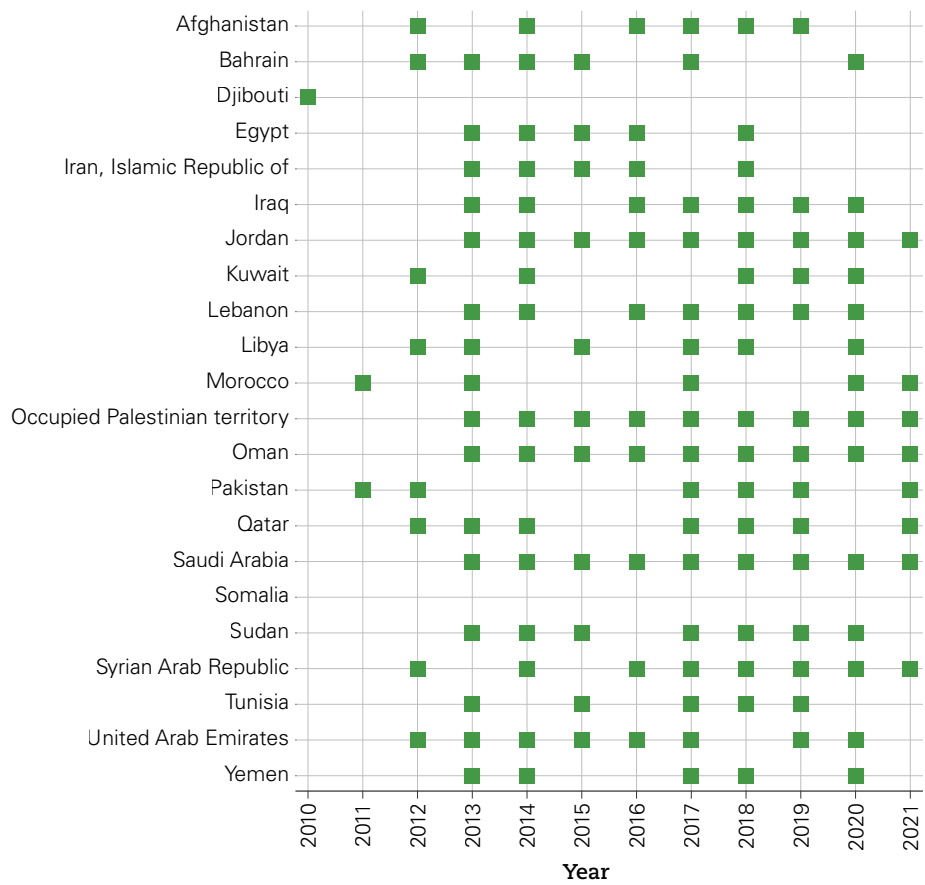
3.c.1 Density of physicians per 10 000 population, 2010–2021



### 3.c.1 Density of nurses and midwives per 10 000 population, 2010–2021



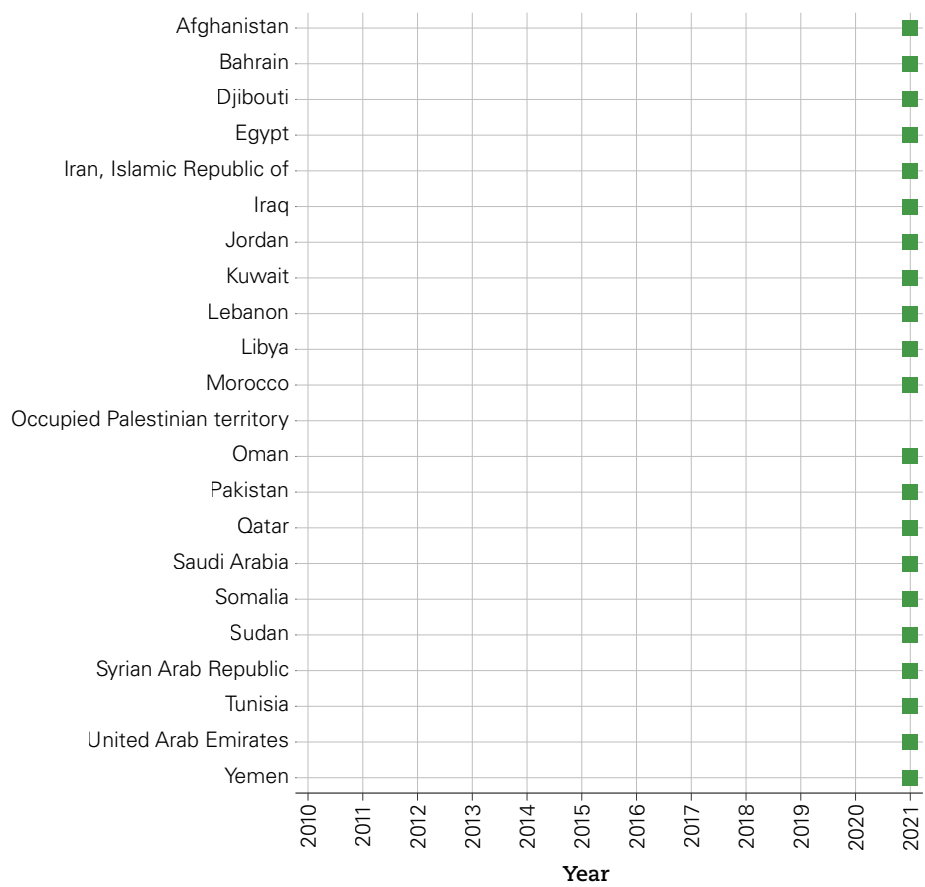
3.c.1 Density of pharmacists per 10 000 population, 2010–2021



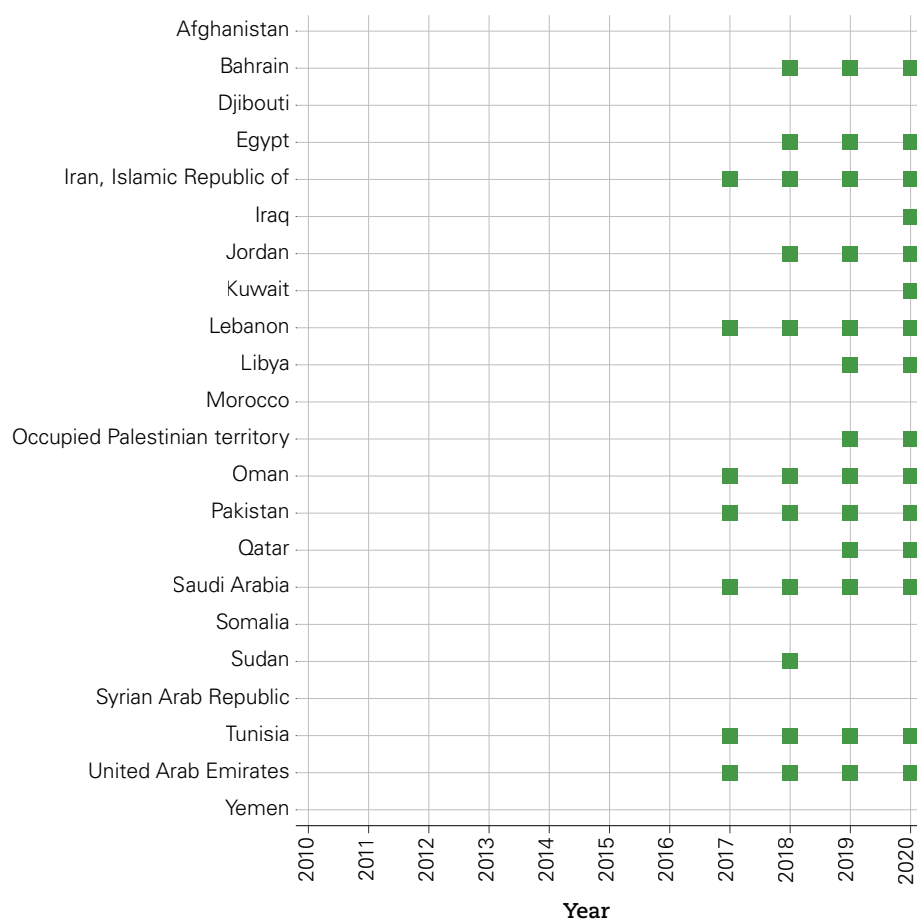
### 3.c.1 Density of dentists per 10 000 population, 2010–2021



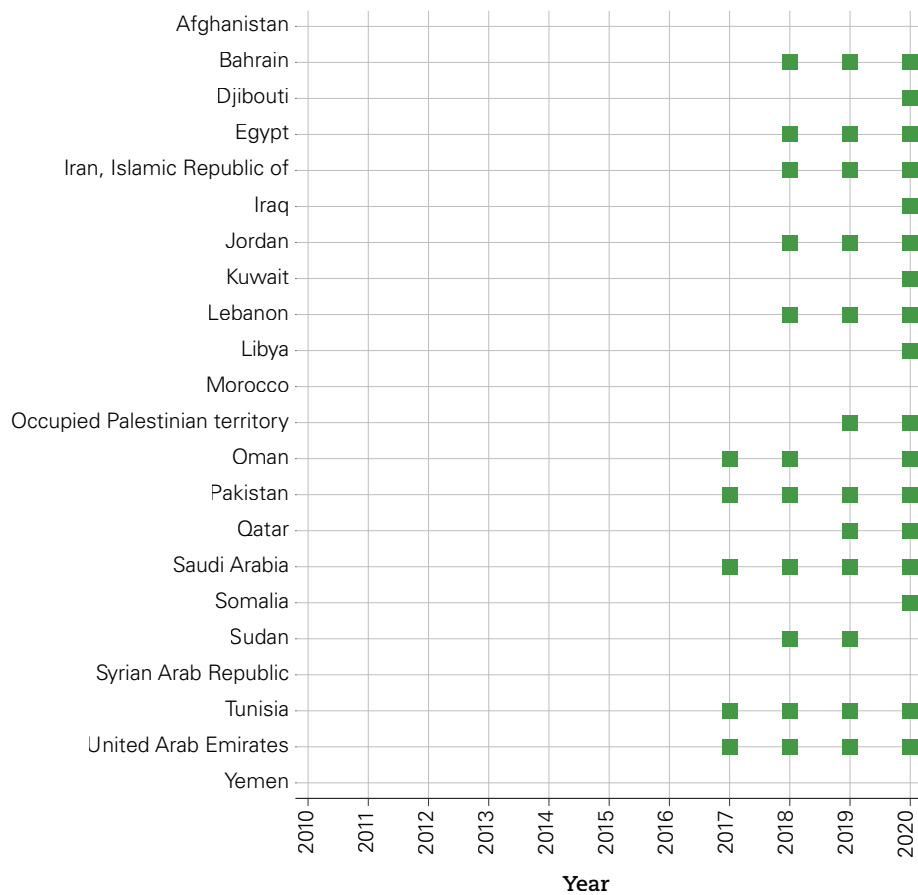
3.d.1 IHR index, 2010–2021

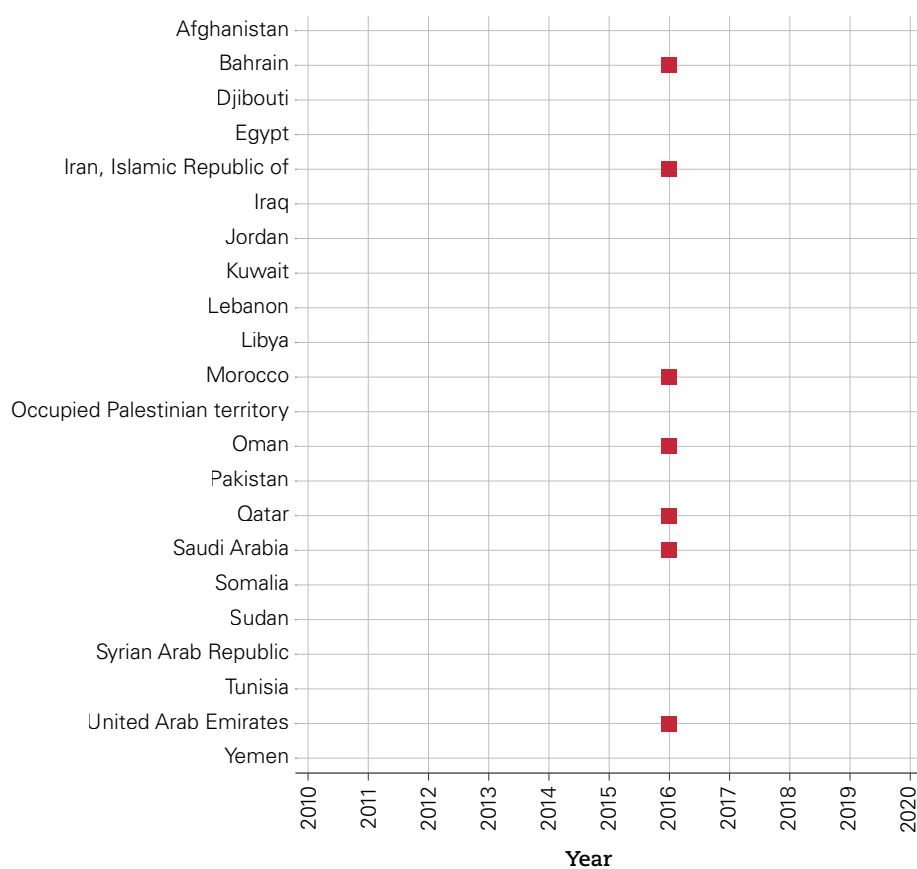




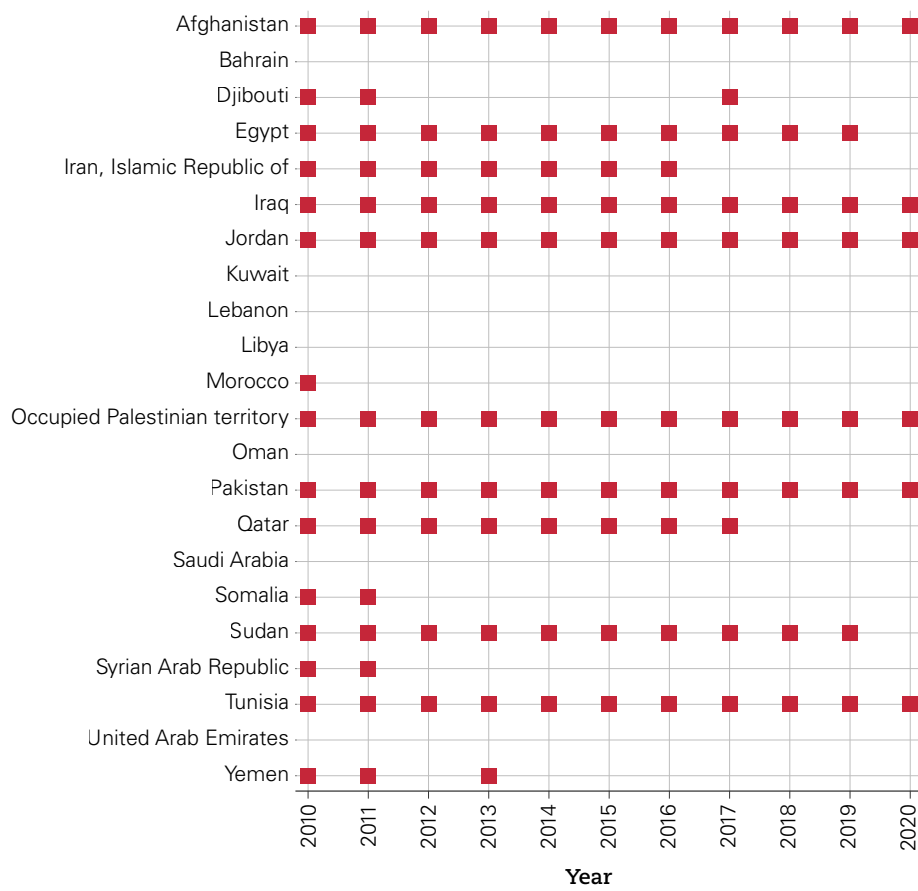
**3.d.2 Bloodstream infections due to ESBL-E.Coli, 2010–2020**

3.d.2 Bloodstream infections due to methicillin-resistant *Staphylococcus aureus*, 2010–2020



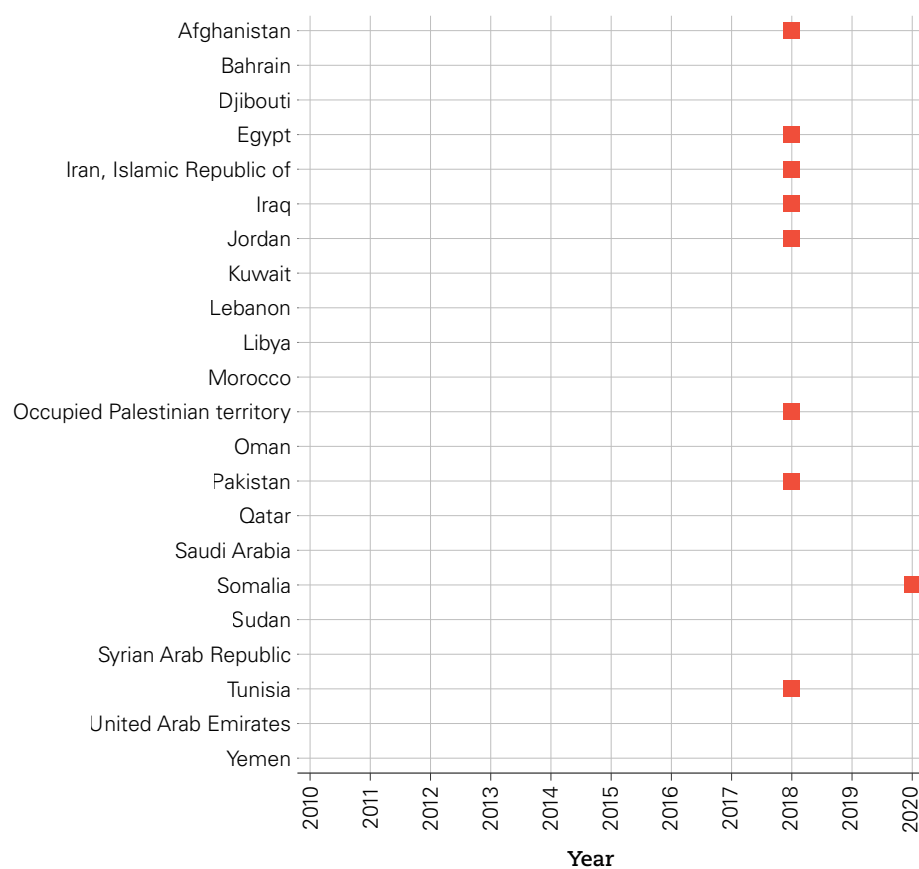
**4.1.1 Proportion of children at the end of primary achieving at least a minimum proficiency level in reading, both sexes, 2010–2020**

4.1.2 Primary education completion rate, 2010–2020

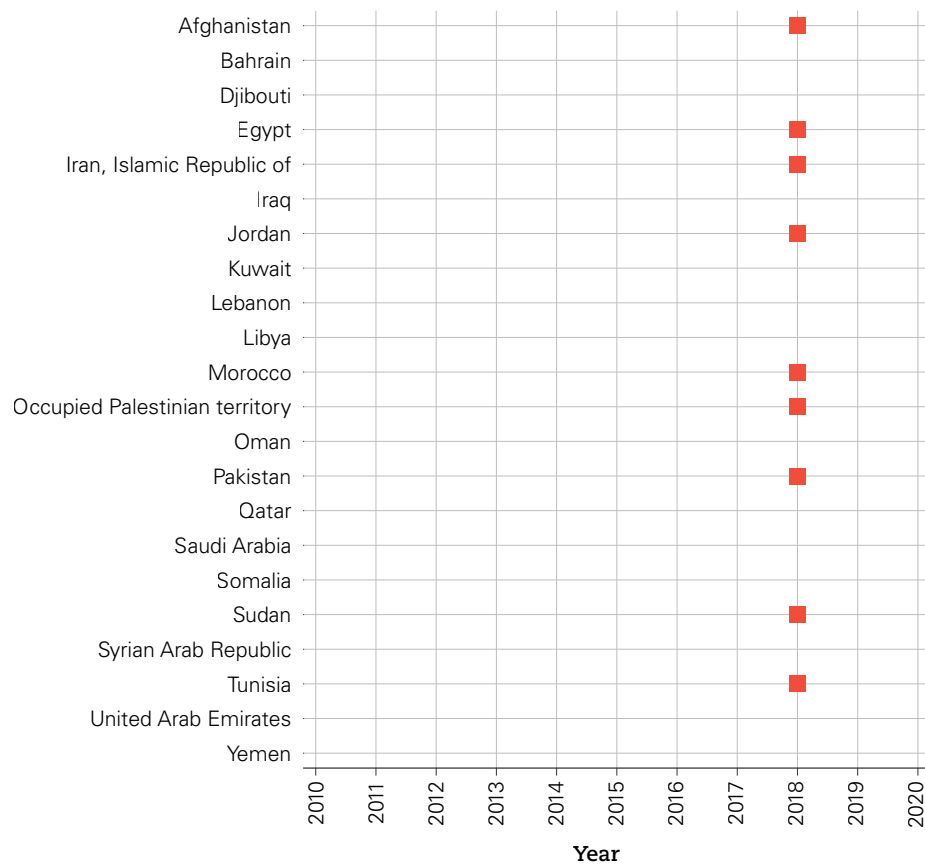


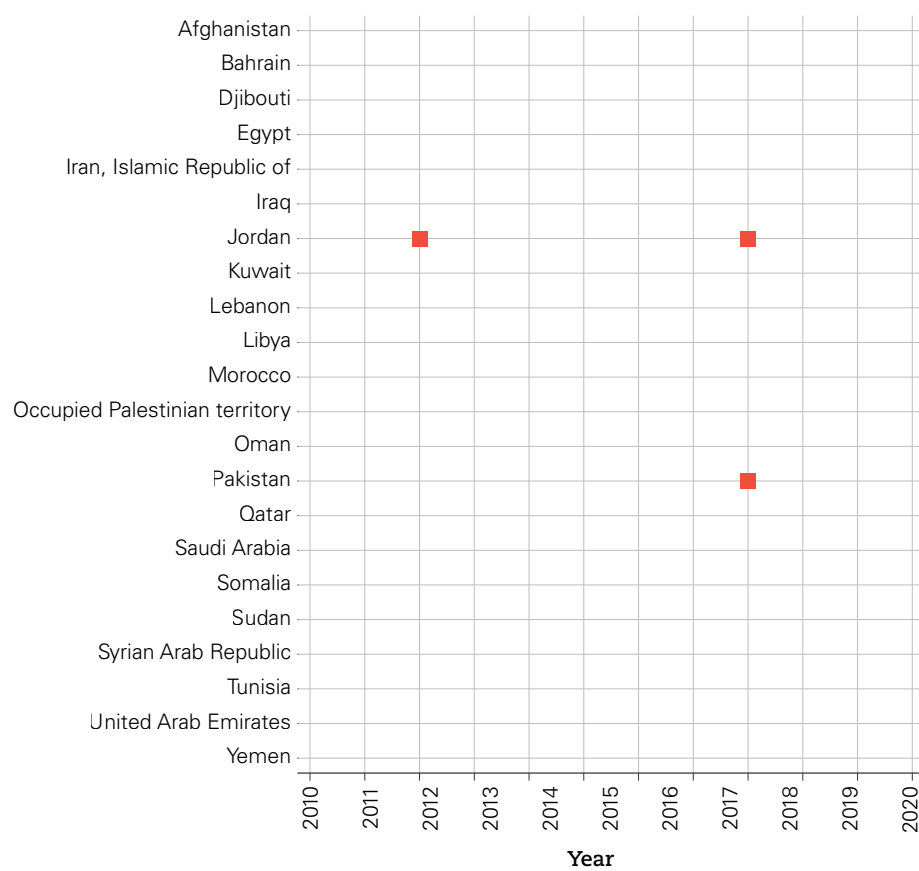
## 5.2.1

## Proportion of ever-partnered women and girls aged 15 years and older subjected to violence (lifetime), 2010–2020

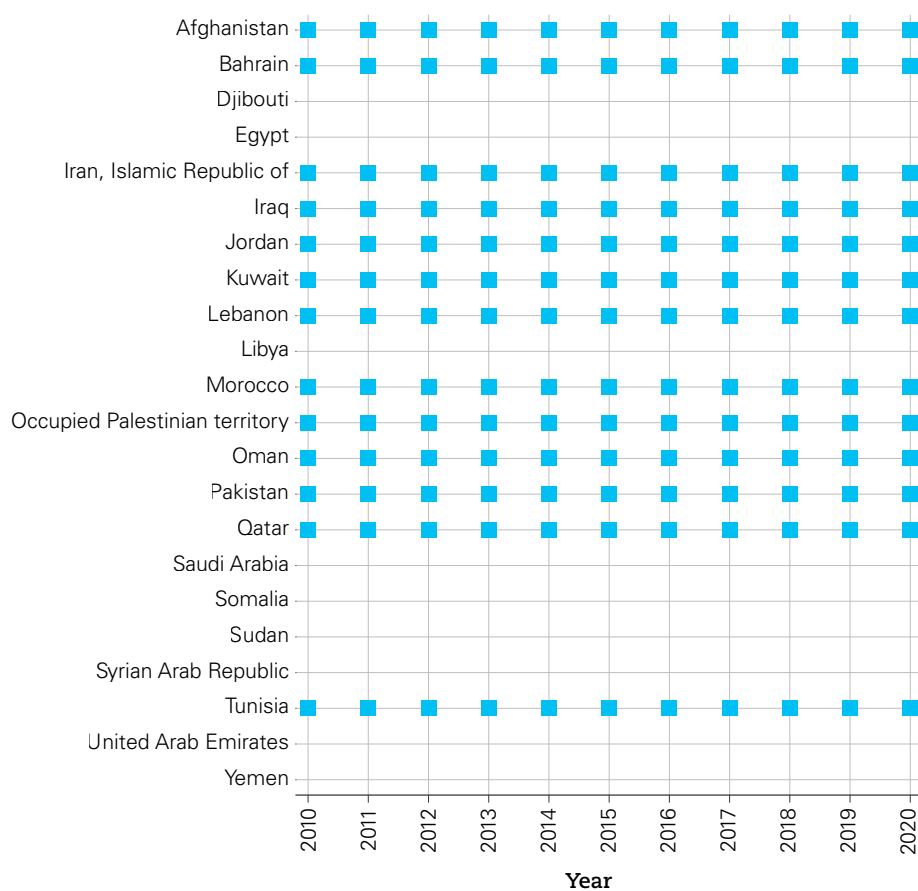


**5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to violence (12 months), 2010–2020**



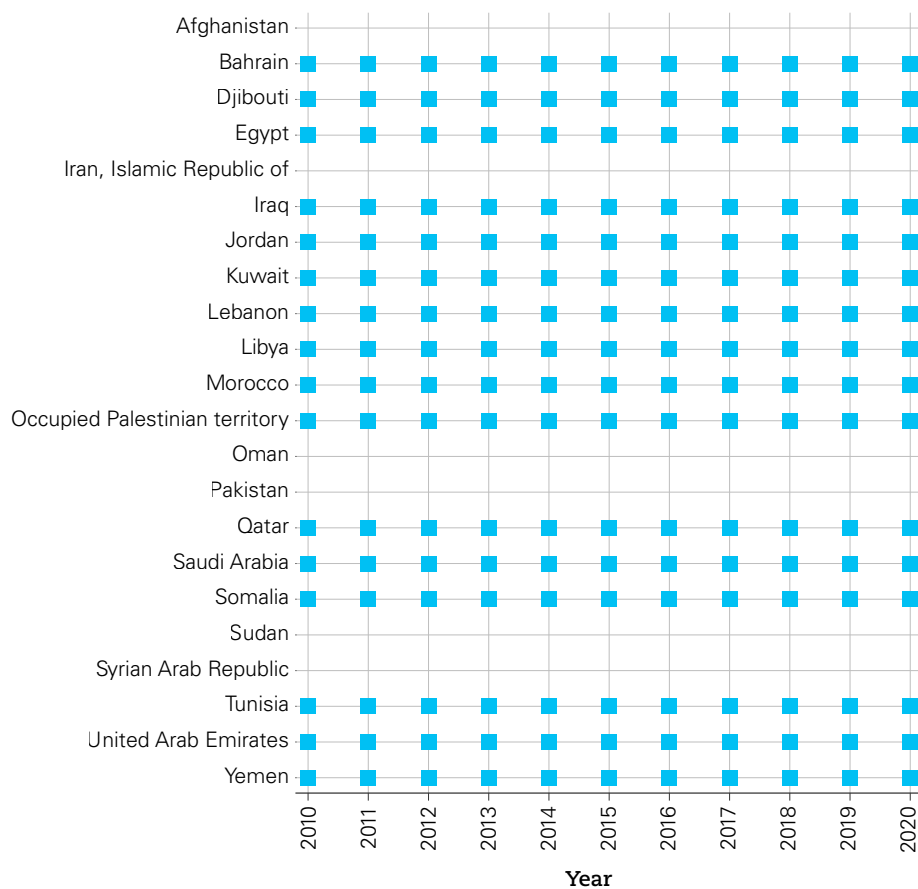
**5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care, 2010–2020**

### 6.1.1 Population using safely managed drinking-water services, 2010-2020

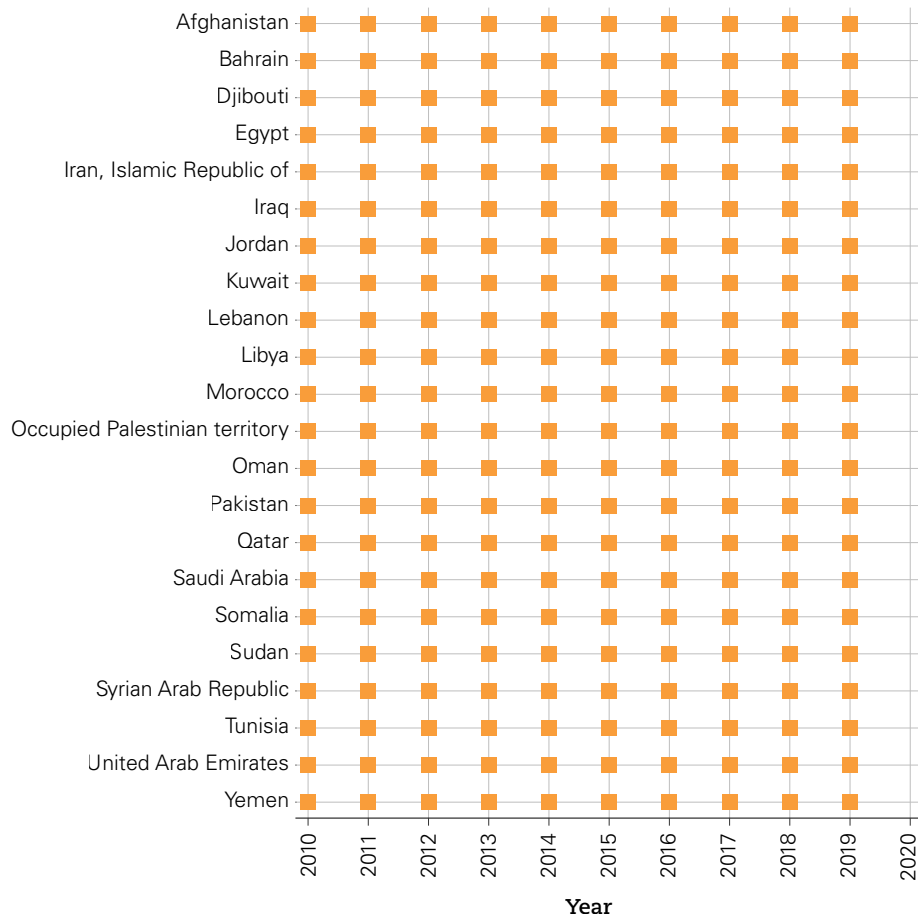




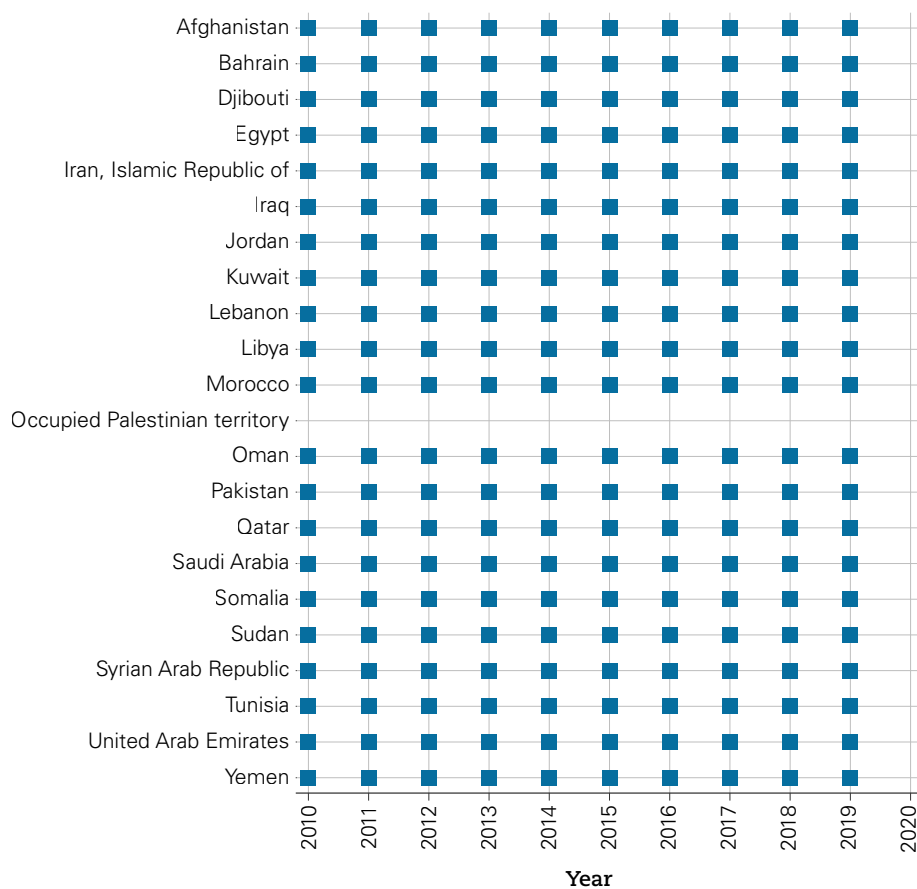
6.2.1 Proportion of population using safely managed sanitation services, 2010–2020



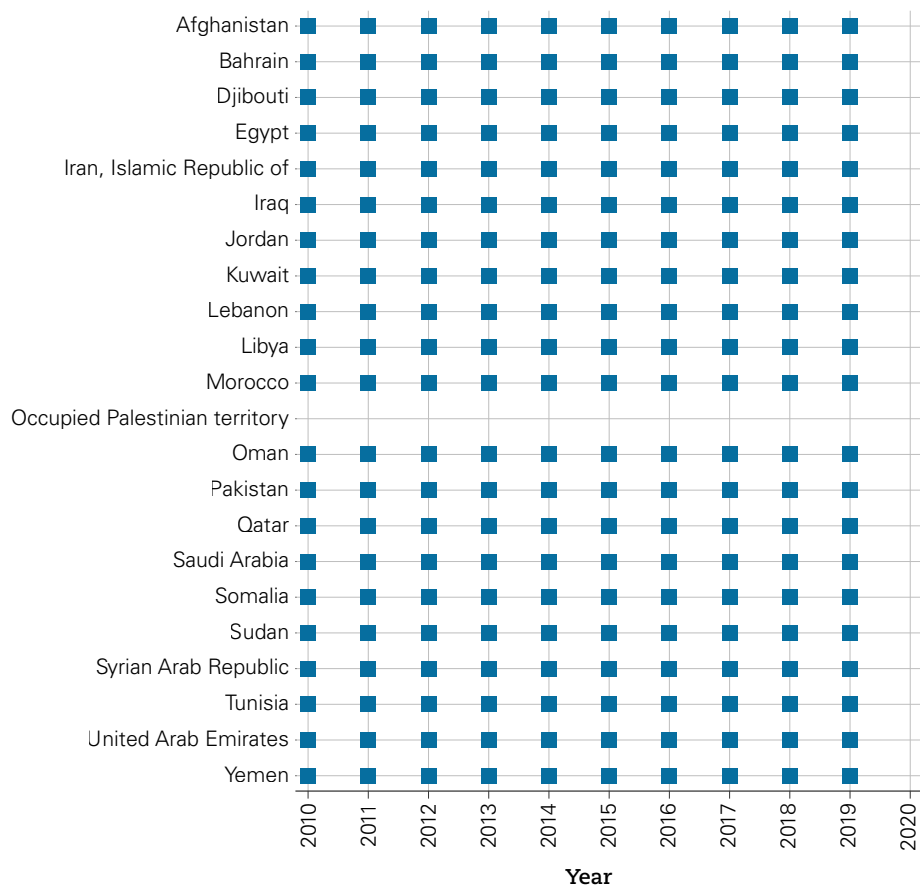
11.6.2 Annual mean levels of fine particulate matter (total), 2010–2020



16.1.1 Estimates of rates of homicides per 100 000 population, 2010–2020

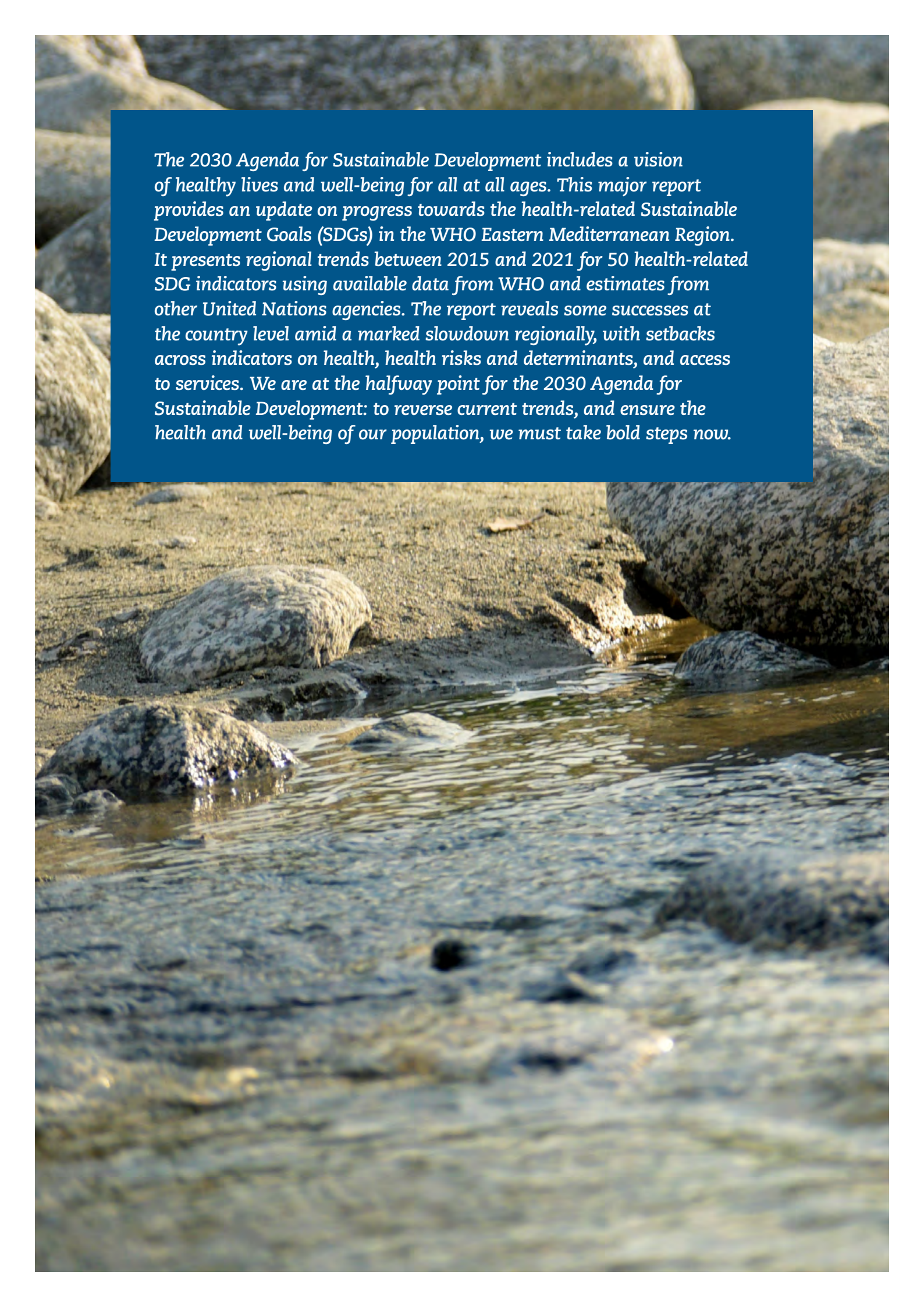


16.2.1 Proportion of children aged 1–14 years who experienced physical violence, 2010–2020



Note: Refer to Annex 1 for a detailed description of each source of data





*The 2030 Agenda for Sustainable Development includes a vision of healthy lives and well-being for all at all ages. This major report provides an update on progress towards the health-related Sustainable Development Goals (SDGs) in the WHO Eastern Mediterranean Region. It presents regional trends between 2015 and 2021 for 50 health-related SDG indicators using available data from WHO and estimates from other United Nations agencies. The report reveals some successes at the country level amid a marked slowdown regionally, with setbacks across indicators on health, health risks and determinants, and access to services. We are at the halfway point for the 2030 Agenda for Sustainable Development: to reverse current trends, and ensure the health and well-being of our population, we must take bold steps now.*